FENTRESS COUNTY

COMMUNITY DIAGNOSIS DOCUMENT

A GUIDE TO HEALTHY COMMUNITIES

1998-1999

Compiled by

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Introduction

Mission Statement

The overall mission of the council is to assist the Department of Health by advising the Department regarding the health problems of Fentress County and thus assist the Department in its responsibility to undertake "Community Diagnosis". The role of the Department of Health is to support the Council by providing the resources needed by the
Council to undertake the work, and by facilitating the "Community Diagnosis" process. The following is a proposed objective statement. The mission of the Council is to assist the Department of Health by:

Developing a community health assessment which includes

- Health problems and needs identification.
- Developing goals, objectives, and plans of action to meet these needs along with identifying and securing resources to address these needs.
- Establishing priorities for all major identified health problems and develop/implement strategies for appropriate interventions.
- Drafting and presenting to the Department of Health the community health assessment.
- Promoting and supporting the importance of reducing the health problems to the Department and the community.
- Maintaining good communications with the Department via periodic reports from the Council through the Regional Health Council Representative and Community Development Staff.

Community Diagnosis

A simple definition (used by the North Carolina Center for Health and Environmental Statistics) of a community diagnosis is " a means of examining aggregate health and social statistics, liberally spiced with knowledge of the local situation, in order to determine the health needs of the community." By using this definition, we acknowledge that significant input from residents of the local area is essential to performing a community diagnosis effectively. Although a great deal of qualified health data can be obtained from the State, the process will only be successful if local citizens are fully involved and are comfortable with the eventual findings. This is why the formation and effective utilization of county health councils are vital in achieving accurate results.

The final outcome of community diagnosis and its products should:

- Provide justification for budget improvement requests submitted to the State Legislature;
- Provide to state-level programs and their regional office personnel information that fosters better planning, promotion, and coordination of prevention and intervention strategies at the local level;
- Serve health planning and advocacy needs at the community level. Here, the community leaders and local health departments provide the leadership to ensure that documented community health problems are addressed.

The end result of the process will be a set of prioritized health goals and proposed interventions to address the needs of the community. The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the community diagnosis process. This document will explain the community diagnosis process and outcomes for Fentress County. We will also provide a historical perspective with details of the council and its formation.

History

"Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

> The Future of Public Health
> Institute of Medicine, 1988

This manual is designed to assist local communities, local and regional health departments, and the state department of health in fulfilling the mission of public health, as defined above. If we, as a society, are to improve the conditions that affect the health of all of us, we must begin in local communities, dealing with local conditions. Health care is a very localized phenomenon. The needs and problems of one community may be very different from other communities, even those in close geographical proximity. Community leaders together with local health departments have a responsibility to play key roles in this effort. They should lead their communities in an examination of local health problems and in the development of plans to overcome those problems.

This mission can be accomplished by implementing the three core functions of public health at all levels of government. They are:

Assessment: The assessment function involves the monitoring and surveillance of local problems, the assessment of needs, and the identification of resources for dealing with them.

Policy Development: Policy development goes hand in hand with leadership, which fosters local involvement and a sense of ownership of these policies. It should emphasize local

needs and should advocate an equitable distribution of public resources and complementary private activities commensurate with community needs.

Assurance: Assurance means that high quality services, including personal health services, which are needed for the protection of the community are available and accessible to all persons. Each community should receive proper consideration in the allocation of federal, state, and local funds for health. Each community should be informed about how to obtain public health services and/or comply with health requirements.

In summary, community-based health planning is a process, which assists local citizens in their respective communities to do the following:

- **Identify the community's health care needs.**
- **Examine the social, economic, and political realities affecting the local delivery of health care.**
- **Determine what the community can realistically achieve in a health care system to meet their needs.**
- **Develop and mobilize an action plan based on analysis for the community.**

The end result of the process should answer three questions for the community:

Where is the community now?
Where does the community want to be?
How will it get there?

The Tennessee Department of Health is committed to assisting communities throughout our state in finding the answers to these questions via the Community Diagnosis process. The following is the Fentress County Community Diagnosis Document, which details the process the Fentress County community utilized to assess its strengths, weaknesses, and gaps in resources. A very thorough analysis of health statistical data, community surveys, resources, and key leaders perceptions of Fentress County's health care status facing the community is presented in document form to be utilized as a baseline document for public relations, grant applications, and as a foundation of the work plan for the future.

Summary

The Tennessee Department of Health Community Development Staff established the Fentress County Health Council in August 1997 with an initial group of twelve community representatives. The Fentress County Health Council has now developed into a council of fifty-nine members. This council consists of various community leaders such as the mayor, county executive, school superintendent, industry representation, health care providers, local law enforcement, various community agencies, and other concerned community leaders as determined appropriate by the council members. (Appendix 1) The Department of Health Community Development Staff facilitates the Community Diagnosis Process. The Community Diagnosis Process seeks to identify community health care problems by analyzing health

statistical data, community surveys, and council perceptions. The initial step in the process is to select a county health council. The basic steps of the Community Diagnosis Process are as follows:

- **Assemble the initiating group**
- **Select the County Health Council**
- **Present data to the council**
- **Discuss and define health problems**
- **Analyze the Behavioral Risk Factor Survey**
- **Distribute and Analyze the Community Health Assessment Surveys**
- **Score/Rank health problems**
- **Design interventions**
- **Develop funding strategies**
- **Assess development and effectiveness of interventions**

During the course of the Community Diagnosis Process, the Fentress County Health Council established by-laws (Appendix 2) that reflect the mission and goals of the council illustrating their commitment to their community. The council typically meets on the 1st Monday of each month from 12:00 to 1:00 p.m. where meetings are open to the public.

County Description

Geographic

- Fentress County is located in the Upper Cumberland region of middle Tennessee.
- Fentress County is located 126 miles from Nashville, 90 miles from Knoxville, and 45 miles from Cookeville.
- This county is predominantly rural and is surrounded by rolling hills and valleys.
- Overton, Pickett, Scott, Morgan, and Cumberland counties in Tennessee surround Fentress County.
- The county is 30 miles from Interstate 40 and 50 miles from Interstate 65.
- The average temperature in July is 68.1 degrees and the average in January is 38.8 degrees with annual average precipitation being 50.5 inches.
- Fentress County is located 1,716 feet above sea level.

Land Area

- Fentress County is a farming community consisting of 498 square miles with population density being 29.4 per square mile.
- The nearest navigable waterway is the Cumberland River located 45 miles away in Celina, Tennessee.
- The major agricultural crops for Fentress County are small grains, vegetables and tobacco.

Economic Base

- The county's median family personal income is $16,405.
- The county's median household personal income is $13,924.
- Fentress County's per capita personal income is $6,927.
- The average weekly income of 1997 wages was $322.
- The individual poverty rate for Fentress County is 32.3%.
- The family poverty rate for Fentress County is 27.3%.
- The 1998 average labor-force total was 6,640, of those, 6,040 were employed and 600 were unemployed giving Fentress County an unemployment rate of 9.0%.
- The major employers in Fentress County include Fentress County General Hospital, OshKosh B'Gosh, Walter Dimension, Quality Home Health Care, and Robinson Mfg. Company.

Demographics

- Fentress County's public education system consists of 6 elementary schools, 2 Junior High/Senior High Schools, 1 private/parochial school and 1 special education school with approximate total enrollment of 2,900 students.
- The number of TennCare enrollees in Fentress County for 1999 is 4,353.
- The 1998 population estimate for Fentress County was 16,184 with projected population for the year 2000 being 16,359.
- The median age for a Fentress County resident is 34.6 years.

Medical Community

- Fentress County has one local hospital that has a total of 87 licensed beds.
- The 1997 resident health profile indicates that 32.5% of Fentress County residents use Davidson County hospitals, while 20.4% utilize the Cumberland County hospital and 17.6% use the hospital in Putnam County.
- There are two health care clinics located in Fentress County.
- Fentress County has one nursing home facility that has a total of 135 licensed beds.
- There are eleven medical doctors and four dentists practicing in Fentress County.

References: Tennessee Department of Health, Upper Cumberland Development District

Community Needs Assessment

Primary Data

Fentress County Community Health Assessment Survey

The Community Health Assessment Survey provides a profile of perceived health care needs and problems facing the community. Its purpose is to obtain subjective data from a cross section of the health care services, problems and needs in the county. The survey includes questions about the health and social problems affecting the community as well as the availability, adequacy, accessibility and level of satisfaction of health care service in the community. The community survey is not a scientific random sample of the community, however it does represent a cross section of the community, i. e. young families, single parents, the elderly, farmers, business leaders, rural residents, etc. The community development staff distributed the Community Health Assessment Survey to the health council members, who then circulated the surveys throughout the community. Results of the survey were tabulated and analyzed using the "Epi Info" computer software. The community development staff presented the final results and analysis of the survey to the county health council. The following list identifies the perceived problems facing Fentress County based on the survey results.

Adult Alcohol Abuse	**72%**
Smoking	**68%**
Teen Alcohol/Drug Abuse	**67%**
Adult Drug Abuse	**64%**
High Blood Pressure	**64%**
Smokeless Tobacco	**58%**
Unemployment	**53%**
Heart Conditions	**53%**
Stress	**51%**
Diabetes	**50%**
Obesity	**49%**
Poverty	**48%**
Arthritis	46%
Teen Pregnancy	45%
Motor Vehicle Deaths	42%
School Dropouts	39%
Lack of Sex Education	38%
Depression	38%
Breast Cancer	37%
Domestic Violence	35%
Child Abuse/Neglect	34%
Lung Cancer	33%
Crime	33%
Other Cancer	32%
Eating Disorders	31%

Top Ten Issues Highlighted

Influenza	29%
Asthma	28%
Pneumonia	28%
Poor Nutrition for the Elderly	27%
Poor Nutrition for Children	24%
Youth Violence	22%
Colon Cancer	20%
Prostrate Cancer	18%
Sexually Transmitted Diseases	18%
School Safety	15%
Water Pollution	15%
Other Accidental Deaths	13%
HIV/AIDS	12%
Air Pollution	10%
Teen Suicide	9%
Hepatitis	9%
On the Job Safety	8%
Lack of Childhood Vaccinations	7%
Homelessness	7%
Adult Suicide	7%
Tuberculosis	6%
Toxic Waste	6%
Gangs	5%
Homicide	4%

Fentress County
Availability of Services

"Adequate" (50% or greater)		"Not Adequate" (25% or greater)	
1) Pharmacy Services	90%	1) Specialized Doctors	55%
2) County Health Department Services	80%	2) Recreational Activities	51%
3) Home Health Care	79%	3) Women's Health Services	37%
4) Ambulance/Emergency Room Services	78%	4) Child Abuse/Neglect Services	36%
5) Local Family Doctors	77%	5) Health Insurance	35%
6) Child Day Care	71%	6) School Health Services	34%
7) Dental Care	65%	7) Mental Health Services	33%
8) Pregnancy Care	64%	7) Alcohol/Drug Treatment	33%
9) Family Planning	61%	8) Emergency Room Care	31%
10) Eye Care	60%	9) Hospital Care	30%
11) Emergency Room Care	59%	10) Health Education /Wellness Services	28%
12) Pediatric Care	57%	11) Adult Day Care	27%
13) Hospital Care	56%	12) Dental Care	25%
14) Nursing Home Care	55%	12) Meals on Wheels	25%

Personal Information

- The majority of the people completing the survey were from Jamestown and Clarkrange, and 78% have lived in the county for more than ten years.
- The average age for the survey respondents was between 30-39 years of age with 13% being single and 70% married.
- The participant response noted that 91% had health insurance, 36% were TennCare enrollees, and 7% receive either SSI or AFDC.
- The personal information reported on the survey revealed that 68% of the respondents were currently employed, 31% were not employed.

The Community Health Assessment Survey was given to members of the Fentress County Health Council and these members distributed the survey through out the community. There were a total of 306 questionnaires returned for analysis. The council members were pleased with the number of respondents and felt this was a good representation of the residents living in Fentress County. The council felt that the survey results were indicative of the perceptions of the health care needs and issues in Fentress County. The result of the Community Health Assessment Survey was discussed with the council members along with profile information about the survey respondents. The findings of the survey revealed that **adult and teen alcohol/drug abuse, smoking/smokeless tobacco, high blood pressure and heart conditions** are perceived as top community concerns. Many council members indicated they were surprised that poverty and unemployment did not rank higher in the top ten.

Behavioral Risk Factor Survey

The Behavioral Risk Factor Survey (BRFS) is a random telephone survey, coordinated through the Centers for Disease Control, which collects information from adults on health behaviors and knowledge related to leading causes of death in each of the states. Approximately 200 interviews were obtained from Fentress County. About half of all deaths occurring annually are now attributed to modifiable behavioral risks. In addition to determining what types of health risks are most prevalent in the population, the BRFS data will be very useful in determining what types of interventions are most needed for other health problems such as excess deaths from a particular chronic disease. A modified version of the standard BRFS was developed specifically for the "Community Diagnosis" process. In addition to the questions on the standard BRFS survey, a series of health issues are listed. The respondent is asked if the issue is a "Definite Problem", "Somewhat of a Problem", "Not a Problem", or "Not Sure". The list of the health issues with frequency of response as a "Definite Problem" is as follows:

Tobacco Use	**62%**	**Top Ten Issues**
Alcohol Abuse	**49%**	**Highlighted**
Cancer	**48%**	
High Blood Pressure	**45%**	
Arthritis	**45%**	
Drug Abuse	**41%**	
Obesity	**39%**	
Heart Conditions	**36%**	
Diabetes	**32%**	
Health Problems of the Lungs	**31%**	
Teen Pregnancy	**28%**	
Animal Control	14%	
Environmental Issues	11%	
Violence in the Home	10%	
Mental Health Problems	5%	
STD's	3%	
Suicide	3%	
Other Violence	1%	

Fentress County's Access to Care Issues
Percent Saying Definite Problem

Transportation to Health Care	9%
Access to Dental Care	8%
Access to Assisted Living Services	6%
Access to Physicians or Doctors	5%
Access to Hospitals	5%
Access to Birth Control Methods	3%
Access to Nursing Home Care	3%

Access to Prenatal Care	2%
Access to Pharmacies, Medicines	1%

Other Issues to Consider

Tobacco Use

Percent of respondents reporting smoking at least 100 cigarettes in their life:
Yes: 43%
No: 56%

Percent of respondents that report current cigarette use:
Daily Use: 34%
Some Use: 13%
Not At All: 53%

Questions Regarding Mammograms

Percent of women reporting having a mammogram:
Yes: 59%
No: 40%

Reasons reported for not having a mammogram:
Doctor not recommended: 14%
Not needed: 8%
Too young: 39%
No reason: 33%
Not sure/other: 4%

When was last mammogram performed:
In last year: 55%
1-2 years: 17%
> than 2 years: 25%

The survey included health risks, utilization and screening services, and perception of health problems. The findings of the survey revealed that the community perceives **tobacco use, alcohol abuse, cancer, high blood pressure, arthritis, and drug abuse** as top health problems facing the community.

In analyzing the access to care issues as perceived by the community, **transportation to health care and access to dental care, and access to assisted living services** were identified as the top concerns.

Secondary Data

Summary of Data Use

Health Indicator Trends
Fentress County, Tennessee
3-Year Moving Averages

Pregnancy and Birth Data

Data is based on information from the Office of Vital Records, Tennessee Department of Health. All health indicator trends are formatted into three-year moving averages, and reflect a ten-year trend.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
1. Number births/1,000 females	Increasing	Above	Above
2. Percent births to unwed women	Increasing	Above	Below
3. Number teenage pregnancies	Decreasing	Below	Below
4. Number pregnancies/1,000 females	Stable	Above	Below
5. Number pregnancies/1,000 females ages 10-14	Unstable	Below	Below
6. Number pregnancies/1,000 females ages 15-17	Decreasing	Below	Below
7. Number pregnancies/1,000 females ages 18-19	Increasing	Above	Above
8. Percent pregnancies to unwed women	Increasing	Below	Below
9. Percent of live births classified as low birthweight	Decreasing	Below	Below

10. Percent of live births classified as very low birthweight	Unstable	Below	Below
11. Percent births w/ 1 or more high risk characteristic	Stable	Above	Above
12. Infant deaths/1,000 births	Stable	Below	Below
13. Neonatal deaths/1,000 births	Stable	Below	Below

In analyzing the pregnancy and birth trends, the council focused on the following trends that showed an increasing indicator:

- Percent of births to unwed women
- Number of pregnancies/1000
- Number of pregnancies/1000 females ages 18-19
- Percent of pregnancies to unwed women

Mortality Data

Using information reported by physicians on death certificates, underlying cause of death is coded by staff in Vital Records. The staff uses National Center for Health Statistics rules for assigning codes for underlying cause of death.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
14. White male age-adjusted mortality rate/100,000 population	Decreasing	Above	Above
15. Other races male age-adjusted mortality rate/100,000 population	Unstable	Above	Below
16. White female age-adjusted mortality rate/100,000 population	Increasing	Above	Above
17. Other races female age-adjusted mortality rate/100,000 population	Unstable	Above	Below
18. Female breast cancer mortality rate/100,000 women age 40 or more	Increasing	Below	Below
19. Nonmotor vehicle accidental mortality rate	Unstable	Above	Above
20. Motor vehicle accidental mortality rate	Increasing	Above	Above
21. Violent death rates/100,000 population	Unstable	Below	Below

The above mortality data shows an increasing trend for:

- White female age adjusted mortality rate/100,000 population
- Female breast cancer mortality rate/100,000 women age 40 or more
- Motor vehicle accidental mortality rate

Morbidity Data

Based on the number of incidence (new cases) which occur for a given disease in a specified time frame and the number of prevalence (existing cases) for a disease in a specified time period.

HEALTH INDICATOR	COUNTY TREND	COUNTY COMPARED TO REGION	COUNTY COMPARED TO STATE
22. Vaccine preventable disease rate/100,000 population	Stable	Below	Below
23. Tuberculosis disease rate/100,000 population	Stable	Below	Below
24. Chlamydia rate/100,000 population	Stable	Below	Below
25. Syphilis rate/100,000 population	Stable	Below	Below
26. Gonorrhea rate/100,000 population	Stable	Below	Below

Healthy People 2000 Objectives

In 1991, the Public Health Service of the U.S. Department of Health and Human Services published Healthy People 2000: National Health Promotion and Disease Prevention Objectives. That report was intended to assist both health providers and consumers in addressing measurable targets to be achieved by the year 2000. The data contained in this report addresses health status indicators for births, deaths, selected diseases, and external influences. The following is a comparison of the objectives to Fentress County. The data used for Fentress County is based on 1994-96 three year moving averages.

Healthy People 2000 Compared to Fentress County

Health Status Indicators	Fentress County Rate	Tennessee Rate	Nation's Rate
Death from all causes	622.9	563.1	No Objective
Coronary Heart Disease	163.6	134.8	100
Deaths from Stroke	18.3	34	20
Deaths of Females from Breast Cancer	15.0	22.4	20.6
Deaths from Lung Cancer	60.0	47.5	42
Deaths from Motor Vehicle Accidents	43.4	23.6	16.8
Deaths from Homicide	1.9	12.1	7.2
Deaths from Suicide	2.5	12.6	10.5
Infant Deaths	6.5	9.6	7.0
Percent of Births to Adolescent Mothers	3.7	6.6	None
Low Birthweight	7.3	8.7	5.0
Late Prenatal Care	11.8	19.9	10.0
Incidence of AIDS	*	14.1	-----
Incidence of Tuberculosis	2.1	11.6	3.5

* Three-year cumulative total cases are less than 5.

The health status indicators in bold are the rates for Fentress County that are above the state's objective rates according to Tennessee's Healthy People 2000.

List of Data Sources

TN Department of Health Office of Vital Records
TN Department of Health Picture of the present, 1997
TN Department of Health, Health Access
TN Department of Economic and Community Development
Upper Cumberland Development District
Healthy People 2000

Health Issues and Priorities

Community Process

In summary, the Health Indicator Trends that have shown an increasing trend over the past 10 years include:

- **Percent births to unwed women**
- **Number pregnancies/1000 females**
- **Number pregnancies/1000 females ages 18-19**
- **Percent pregnancies to unwed women**
- **White female age-adjusted mortality rate/100,000 population**
- **Female breast cancer mortality rate 100,000 women age 40 or more**
- **Motor vehicle accidental mortality rate**

In analyzing these trends, the council's awareness of these problems increased dramatically. There was much discussion about the increasing incidence of female breast cancer mortality rates, and the motor vehicle accidental mortality rate.

After a thorough analysis of all data sets, Behavioral Risk Factor Survey, and Community Health Assessment Survey, the council established priorities among a multitude of problems. In order to ensure the accuracy of the council's ranking, the Community Development staff developed a prioritization table that provided a means of comparison between all top issues addressed. This table presents the order ranking of each issue from both surveys and then compares the actual data to each issue. The data may either reinforce or refute the council's perceptions about their top concerns. The Prioritization Table is a culmination of the information presented to the council over the last several months and is provided in a concise and well-organized manner.

FENTRESS COUNTY PRIORITIZATION TABLE

Council Ranking	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Tobacco Use/Smoking/ Smokeless Tobacco	(1)	(2) (5)	In ages 25-44, the mortality rates for malignant neoplasms increased substantially from 1985-87, and remained above the region and the state until 1991-93. The rates drastically increased in 1993-95 to well above the region and state in 1994-96. In ages 45-64, the 10-year trend of deaths from malignant neoplasms has shown a slight decline. In ages 65+, the rates have steadily increased over the past 10 years. Rates for this age group have been well above the region and the state since 1992-94. Lung cancer incidence rates for 1995 were 88.2, with the state's rate being 64.2. There were 17 reported cases for 1995.
Adult Alcohol Abuse	(2)	(1)	In ages 45-64, chronic liver disease & cirrhosis mortality rates increased steadily from 1985-87 through 1990-92. The rate dropped and remained low until 1992-94, and has increased every year since then. The 1994-96 rate is above both the state and the region.
Teen Alcohol and Drug Abuse	(2/5) Addressed Total Population	(3)	In ages 15-24, no deaths were reported from suicide for Fentress county for the years 1986-88 through 1989-91. The suicide rates for years 1990-92 through 1993-95 were above the state and above the region.
Adult Drug Abuse	(5)	(4)	
High Blood Pressure	(4)	(4) Stress Ranked 7th	In ages 25-44, deaths from cerebrovascular disease increased dramatically in 1985-87, and remained well above the state and the region through 1993-95. The rate dropped in years 1994-96. In ages 45-64, deaths from cerebrovascular disease have shown a slight decrease since 1990-92. In ages 65+, the rates have remained fairly stable over the past 10 years. The rates for this age group are high, but fall below the region and the state.
Cancer Breast Cancer Lung Cancer Other Cancer	(3)	 (16) (19) (20)	In ages 5-14, deaths from malignant neoplasms increased dramatically in 1991-93, and remained well above the region and the state. In ages 25-44, the rates increased substantially from 1985-87, and remained above the region and the state until 1991-93. The rates drastically increased from 1993-95 to well above the region and state in 1994-96. In ages 45-64, the 10-year trend has shown a slight decline. In ages 65+, the rates have steadily increased over the past 10 years. The rate for this age group has been well above the region and the state since 1992-94. Lung cancer incidence rate for 1995 was 88.2, with the state's rate being 64.2. There were 17 reported cases for 1995. Breast cancer incidence rate for 1995 was 38.2, with the state's rate being 94.4. There were 4 reported cases for 1995. Incidence rate for "other sites" for 1995 was

Council Ranking	BRFS	Comm. Quest.	Health Indicator Trends (Secondary Data)
Cancer (cont.) Breast Cancer Lung Cancer Other Cancer	(3)	 (16) (19) (20)	14.1, with the state's rate being 27.1. There were 2 reported cases for 1995.
Heart Conditions	(7)	(6)	In ages 25-44, deaths from heart disease have increased dramatically since 1989-91 with the rates being well above the state and the region. In ages 45-64, the rates have remained high and above the state and region over the past 10 years. In ages 65+, deaths from heart disease have remained high and well above the state and the region for the past 10 years.
Obesity	(6)	(9)	See Heart Conditions: Diseases of the Heart trends See High Blood Pressure: Cerebrovascular Disease trends
Diabetes	(8)	(8)	In ages 25-44, deaths from diabetes were above the state and region from 85-87 through 88-90. Since that time, no deaths have been reported for Fentress county through 94-96. In ages 45-64, no deaths were reported from 85-87 through 89-91. Rates have dramatically increased since that time with rates for 94-96 being above the state and region. In ages 65+, death rates for diabetes have increased over the past 10 years with rates remaining above the state and the region since 92-94.
Unemployment	Not Addressed	(6)	Based on the 1996 data, an estimated 7.6% of the civilian labor force in Fentress County are unemployed.
Poverty	Not Addressed	(10)	Approximately 65.8% of the population falls below 200% of the federally designated poverty level. This percentage is the highest in the UC region. There were a reported 7, 222 TennCare enrollees in Fentress county for 1997. According to a report dated May 16, 1998 there are 7,711 TennCare recipients in Fentress county.
Health Problems of the Lungs	(9)	Lung Cancer Ranked 19th	Lung cancer incidence rate for 1995 was 88.2, with the state's rate being 64.2. There were 17 reported cases for 1995. In ages 45-64, deaths from chronic obstructive pulmonary disease have remained consistently above the state and the region over the past 10 years. In ages 65+, the rates are increasing at a steady pace, and have also remained well above the state and the region over the past 10 years.
Teen Pregnancy	(10)	(12)	The number of teenage pregnancies for ages 10-14 is below the state and the region, but has shown an increase since 92-94. Pregnancies for ages 15-17 increased slightly, and were above the region from 85-87 to 91-93, and since then have shown a slight decline with rates for 94-96 being below the state and the region. The number of pregnancies for ages 18-19 have shown an increase beginning in 91-93 with rates for 94-96 being above the state and above the region.

Fentress County Priorities

In order to ensure that all health problems were addressed in the same manner, the council utilized a process termed "Score and Rank". This process is an objective, reasonable and easy to use procedure that determines the priority issues. Each health and social concern is assigned a rank based on the size and the seriousness of the problem in conjunction with the knowledge about the effectiveness of potentially available interventions. The Score and Rank Process is outlined below:

Score and Rank Process

Consider the following:

Size: This reflects the percentage of the local population affected by the problem.
The largest percentage will be ranked 1.
The smallest percentage will be ranked 13.

Seriousness: The most serious problem will be ranked 1.
The least serious problem will be ranked 13.

Keep in mind:

- What is the emergent nature of the health problem? Is there an urgency to intervene? Is their public concern? Is the problem a health problem?
- What is the severity of the problem? Does the problem have a high death rate? Does the problem cause premature morbidity or mortality?
- Is there actual or potential economic loss associated with the health problems? Does the health problem cause long term illness? Will the community have to bear the economic burden?
- What is the potential or actual impact on others in the community?

STEP 1: Assign a rank for size.

1 being the highest rank (the largest percentage)
13 being the lowest rank (the smallest percentage)

Assign a rank for seriousness.

1 being the most serious
13 being the least serious

STEP 2: Add size and seriousness

STEP 3: The final rank will be determined by assessing the totals. The lowest total will have a final rank of 1 and the highest total will have a final rank of 13.

The results of the Score and Rank Process were:

TOP ISSUES

1) Tobacco Use/Smoking/Smokeless Tobacco
2) Teen Alcohol and Drug Abuse
3) Adult Alcohol Abuse
4) Adult Drug Abuse
5) Poverty
6) Obesity
7) High Blood Pressure
8) Cancer(Breast, Lung and Other)
9) Unemployment
10) Heart Conditions
11) Diabetes
12) Teen Pregnancy
13) Health Problems of the Lungs

At this point in the prioritization process, the Fentress County Health Council members performed the PEARL TEST. Once health problems have been rated for size, seriousness and effectiveness of available interventions, they should be judged on the factors of: Propriety, Economics, Acceptability, Resources and Legality. The initial letters of these factors make up the acronym **PEARL**. The PEARL TEST is an additional way to gain a consensus of the council for the priority issue. The following is a brief description of the PEARL TEST.

***Propriety*:**	Is a Program for the health problem suitable?
Economics:	Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
Acceptability:	Will the community accept a program? Is it wanted?
Resources:	Is funding available or potentially available for a program?
Legality:	Do current laws allow program activities to be implemented?

The top issues according to the PEARL Test were:

1) **Teen Alcohol and Drug Abuse**
2) **Unemployment**
3) **Poverty**

Future Planning

Through the Community Diagnosis Process, it was determined that the top issue of concern was the teen alcohol and drug problem in Fentress County. The future plans of the Fentress County Health Council are to go through the action planning steps.

Taking Action Outline

The *Taking Action* cycle is a systematic approach to problem solving.
There are five phases of the cycle:

A	Phase 1	*A*ssess the Situation
C	Phase 2	Determine *C*auses
T	Phase 3	*T*arget Solutions
I	Phase 4	Design *I*mplementation
ON	Phase 5	Make it *On*going

Phase 1 **A**ssess the Situation

- Identifying priority health issue.
- Answering the question, "How does the priority health issue affect your community?"
- Writing mission statement based on answers to questions.
- Making decision to pursue health-related concern or to select another ingredient to work on.
- Listing community resources that could be applied to the priority health issue.
- Developing answers to the following questions:
  - **Who** are the people/group being targeted?
  - **What** do they need?
  - **Where** do they need it?
  - **When** is it needed?
- Identifying additional data and ways to gather information.

Phase 2 Determine **C**auses

- Reviewing who, what, where, and when for current health concerns and introduction to the "why".
- Discussing possible causes and the difference between a cause and a symptom.
- Listing causes of the problem, grouping them, and identifying the ones that are creating the problem issue.
- Identifying additional data that may be needed from the target group.

Phase 3 **T**arget Solutions and Ideas

- Targeting a solution.
- Identifying potential solutions that offer the greatest benefit for the causes.
- Listing possible barriers to the solution and actions to correct them.
- Developing criteria for a good solution.
- Revising the health-related concern into a problem statement which includes the health-related concern, the target population, the cause(s), and the solution or plan of action.

Phase 4 Design **I**mplementation, the Action Plan

- Setting goals and objectives.
- Forming work groups for the following categories: community partners, equipment needs, time lines, marketing plan, and staff needs/training.
- Presenting group/committee reports.
- Finalizing content of the categories.
- Restating goals and objectives.
- Forming budget group.

  Budget revisions and final approval of *Action Plan*.

Phase 5 Make it **On**going.

- Forming committees for:
  Evaluation
  Development/Sustainability
  Strategies for short and long term funding options.

Appendices

Appendix 1

Council Makeup

Smith County Health Council

Janet Masters, Director
Fentress County Health Department

Miller Leonard
P.O. Box 309
Allardt, TN 38504

Kevin Poore
Dale Hollow Mental Health Center
501 Spruce Street
Livingston, TN 38670

Senator Lincoln Davis
1690 Delk Creed Road
Pall Mall, TN 38577

Richard Wentworth, Resident Director
CAMP-E-SUN-ALEE
421 Catfish Farm Road
Deerlodge, TN 37726

Ken Taylor, Director
Challengers Inc.
P.O. Box 941
Jamestown, TN 38556

Theresa Ormes
Special Projects
Building 606, 7th Avenue
Smyra, TN 37167

Linda Patterson
Regional Health Office

Mr. David Conaster
Principle
York Elementary School
P.O. Box 1310
Jamestown, TN 38556

Patrick Gray
Fentress County General Hospital
P.O.Box 1500
Jamestown, TN 38556

Mr. Ray Atkinson
Sheriff
P.O. Box 730
Jamestown, TN 38556

Representative John Mark Windle
P.O. Box 707
Livingston TN 38570

Ms. Janice Davis
P.O. Box 923
Jamestown TN 38556

Attention: Darlene
Alish Horst, R.N.
421 Catfish Farm Road
Deerlodge, TN 37726

Kay Bridges
120 South York Lane
Jamestown, TN 38556

Lee Linder
Board of Education
P.O. Box 471
Jamestown, TN 38556

Becky Hawks, TN Dept. of Health
Bureau of Health Services Administration
4th Floor Cordell Hull Building
425 5th Avenue North
Nashville, TN 37247-4501

William Cody
Clarkrange High School
Clarkrange, TN 38553

Barbara Duncan
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Jamestown, TN 38556

Keith Smith
P.O. Box 1500
Jamestown, TN 38556

Wendell Reagan
Fentress County Sheriff's Dept.
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Jamestown, TN 38556

Darrell Rains
PineHaven School
Jamestown, TN 38556

Gwenith Duncan
Mayor
P.O. Box 670
Jamestown, TN 38556

Gerald Huddleston
Board of Education
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Jamestown, TN 38556

Bob Pile
199 Greenhouse Lane
Pall Mall, TN 38577

Brenda Williams
Fentress County Health Department

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Jamestown,TN 38556

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C/O YAI
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Jamestown, TN 38556

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Jamestown, TN 38556

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Jamestown, TN 38556

Charles LaRue
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Jamestown, TN 38556

Mike Jones
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Clarkrange, TN 38553

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Jamestown, TN 38556

Cecil Franklin
Grimsley Elementary School
Grimsley, TN 38565

Brenda Allred
P.O. Box 844
Jamestown, TN 38556

David Beaty
County Executive
P.O. Box 1128
Jamestown, TN 38556

Tommy Maddox
Allardt School
Allardt, TN 38504

Leonard Bilbrey
C/O Mundy's Funeral Home
P.O. Box 268 Jamestown, TN 38556

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Jamestown, TN 38556

Russell Beaty
C/O YAI
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Jamestown, TN 38556

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Jamestown, TN 38556

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Jamestown, TN 38556

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Jamestown, TN 38556

Margret Pile
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Jamestown, TN 38556

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Regional Health Office

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Livingston, TN 38570

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Livingston, TN 38570-1509

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P.O. Box 941
Jamestown,TN 38556
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785 East Rock Query Road
Clarkrange, TN 38533
Billie Sue Wright
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Jamestown, TN 38556

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Jamestown, TN 38556
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Byrdstown, TN 38549

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Jamestown, TN 38556
Jason Poore
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Allardt, TN 38504
Betty Bowden
Fentree Courier
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Jamestown, TN 38556
Angie Beaty
American Cancer Society
508 State Street
Cookeville, TN 38501
Bekka Taylor
115 Peavyhouse Street
Jamestown, TN 38556

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Jamestown, TN 38556
Fentress County Nursing Home
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Jamestown, TN 38556
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Jamestown, TN 38556

Denise Romer DHS Area Manager
P.O. Box 68
Jamestown, TN 38556

Appendix 2

BY LAWS FOR
FENTRESS COUNTY HEALTH COUNCIL

ARTICLE 1-NAME

The name of this council shall be the FENTRESS COUNTY HEALTH COUNCIL (hereafter referred to as "Council") and will exist within the geographic boundaries of Fentress County, Tennessee. The council shall exist as a non-incorporated, not-for-profit, voluntary membership community service organization.

ARTICLE II -PURPOSE

The Council is to act as an independent advisory organization whose purpose is to facilitate the availability, accessibility and affordability of quality health care within Fentress County, Tennessee.

ARTICLE III -GOALS

The Council will promote the prevention of premature death, disability and illness by developing a Fentress County community health plan for recommendation to the Department of Health. From its analysis of the health needs of the county, the Council will:

1. Formally define health care problems and needs within the community.
2. Develop goals, objectives and plans of action to address those needs.
3. Identify departmental/organizational work teams and community agencies that should coordinate efforts with respect to each health problem.
4. Establishing priorities for all identified health problems.
5. Evaluate successes or failures of priorities and report such to the community.

ARTICLE IV-AUTHORITY

The Council shall exist as an advisory and support body to the Tennessee Department of Health solely for the purposes stated herein and not be vested with any legal authority described to the Tennessee Department of Health, the State of Tennessee or any of its political subdivisions. Recommendations of the Council will not be binding upon the Tennessee Department of Health and the Council is not granted authority to act on behalf of the Department of Health without specific written authorization. The Council shall not have the authority to generate, or otherwise receive funds or property on its own behalf. Further, the Council shall not generate or receive monies or property on behalf of the Tennessee Department of Health without specific prior approval in writing. Should such authorization be issued, any monies or property thereby arising shall be designated for and relinquished directly to the Tennessee Department of Health for appropriate accounting and allocation according to the Tennessee Department Health applicable

Department of Health Policy. The Council shall provide the Tennessee Department of Health a strict accounting of all financial transactions arising from Council activities. The financial records and accounts of the Council will be made to the Tennessee Department of Health or its auditors for examination at any time upon reasonable request.

ARTICLE V-MEMBERSHIP

The Council shall consist of no less than 15 nor more than 30 members. A membership vacancy on the Council shall not prevent the Council from conducting business. Membership will be restricted to the residents of Fentress County, Tennessee. The Council shall consist of an adequate number of voting members so as to be effectively representative of all segments of the community. Leaders in the areas of health care, finance, business, industry, civic organizations, social welfare organizations, advocacy groups, law enforcement and government may be invited to serve. Initial members of the Council shall be appointed by the Director of the Upper Cumberland Regional Office, Tennessee Department of Health upon receiving recommendation from County officials. Future members to fill Council vacancies will be appointed by the Council. The Council shall have the right to remove Council members for good cause shown after notice and hearing before the Council as a whole. A two-thirds vote of the entire Council is required for removal. Automatic removal results when a member misses three (3) unexcused consecutive meetings or six (6) meetings a calendar year. Members shall serve a term of 3 years. Additional terms may be served as deemed appropriate by the Council.

ARTICLE VI-OFFICERS

The officers of the Council shall consist of the Chairperson, Vice-Chairperson, Secretary, and Treasurer.
The Chairperson will be elected by majority vote of the Council from nominees among its members. The Chairperson will preside over all meetings of the Council and will set the agenda for each meeting.
The Vice-Chairperson will be elected by majority vote of the Council from nominees among its members. The Vice-Chairperson will preside in the absence of the Chairperson and assume duties of the Chairperson.
The Secretary will be elected by majority vote of the Council from nominees among its members. The Secretary will record the business conducted at meetings of the Council in the form of minutes and will issue notice of all meetings and perform such duties as assigned by the Council.
The Treasurer shall keep the account of all monies arising from the Council activities. No less than annually, or upon request, the Treasurer shall issue a financial report to the membership.
Officers shall be elected at the meeting in or following July of each year for a term of one year. Officers may be re-elected to serve additional terms.

ARTICLE VIII-MEETINGS

The Council will conduct regularly scheduled meetings at intervals of no less than once every two- (2) months. They are to be held at a time and place specified by the consensus of the Council membership.
The Council chairperson may call a special meeting, as deemed appropriate, upon five working days written notice to the membership.
A Quorum shall consist of a majority of voting members present at the Council meeting.
All Council meetings are open to the general public and the public is encouraged to attend.
The latest published edition of Robert's Rule of Order shall be the authority for questions pertaining to the conduct of Council business.

ARTICLE VIII-COMMITTEES/COUNCILS/TASK FORCES

The Council may establish such standing or special committees as deemed appropriate for the conduct of it's business. Committee membership will be assigned by the Chairperson and may consist of both Council members and other concerned individuals who are not active members of the Council.
Subcommittees may be appointed specializing in concerns relative to specific populations or subject matter.
Task Forces may be appointed as needed to accomplish specific short-term objectives.

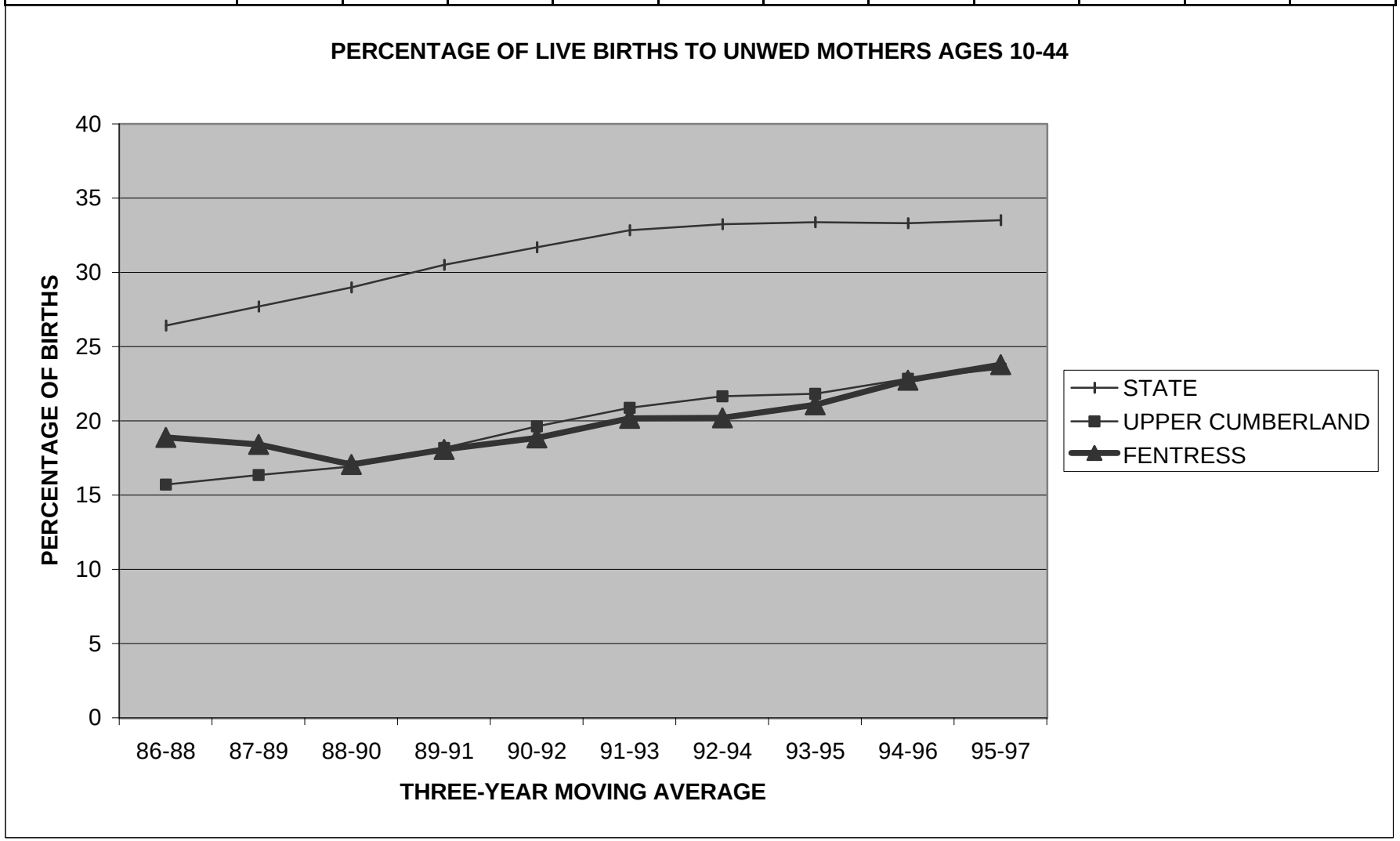
ARTICLE IX-APPROVAL AND AMENDMENTS

The Bylaws will become effective upon approval by a majority vote of the membership of the Council. Thereafter, these Bylaws may be amended or repealed at any regular or special meeting called for the purpose by a majority vote of the voting members present, provided that the proposed additions, deletions or changes have been submitted in writing to all Council members not less than thirty (30) days prior to the meeting at which formal action on such amendments are sought.

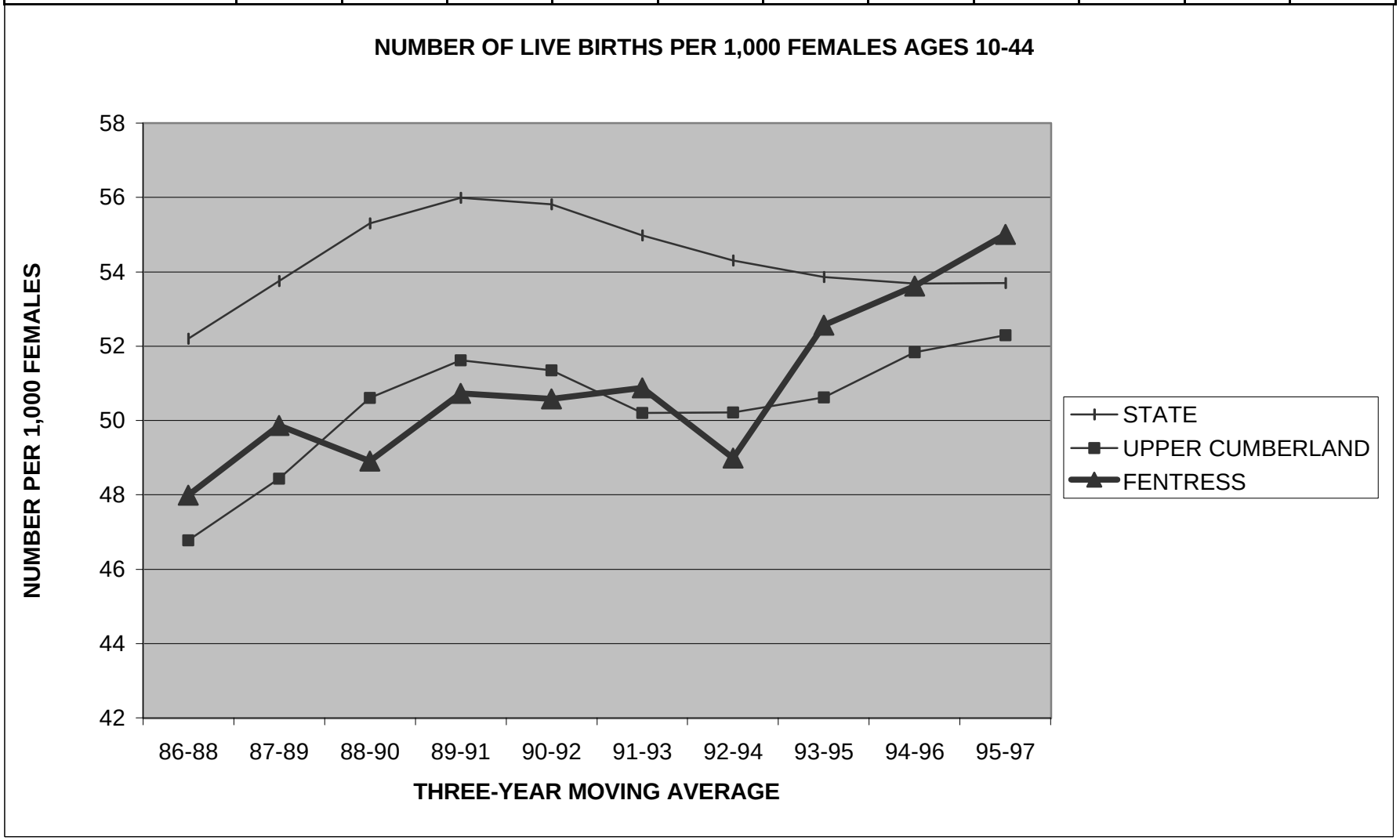
Appendix 3

Pregnancy and Birth Data

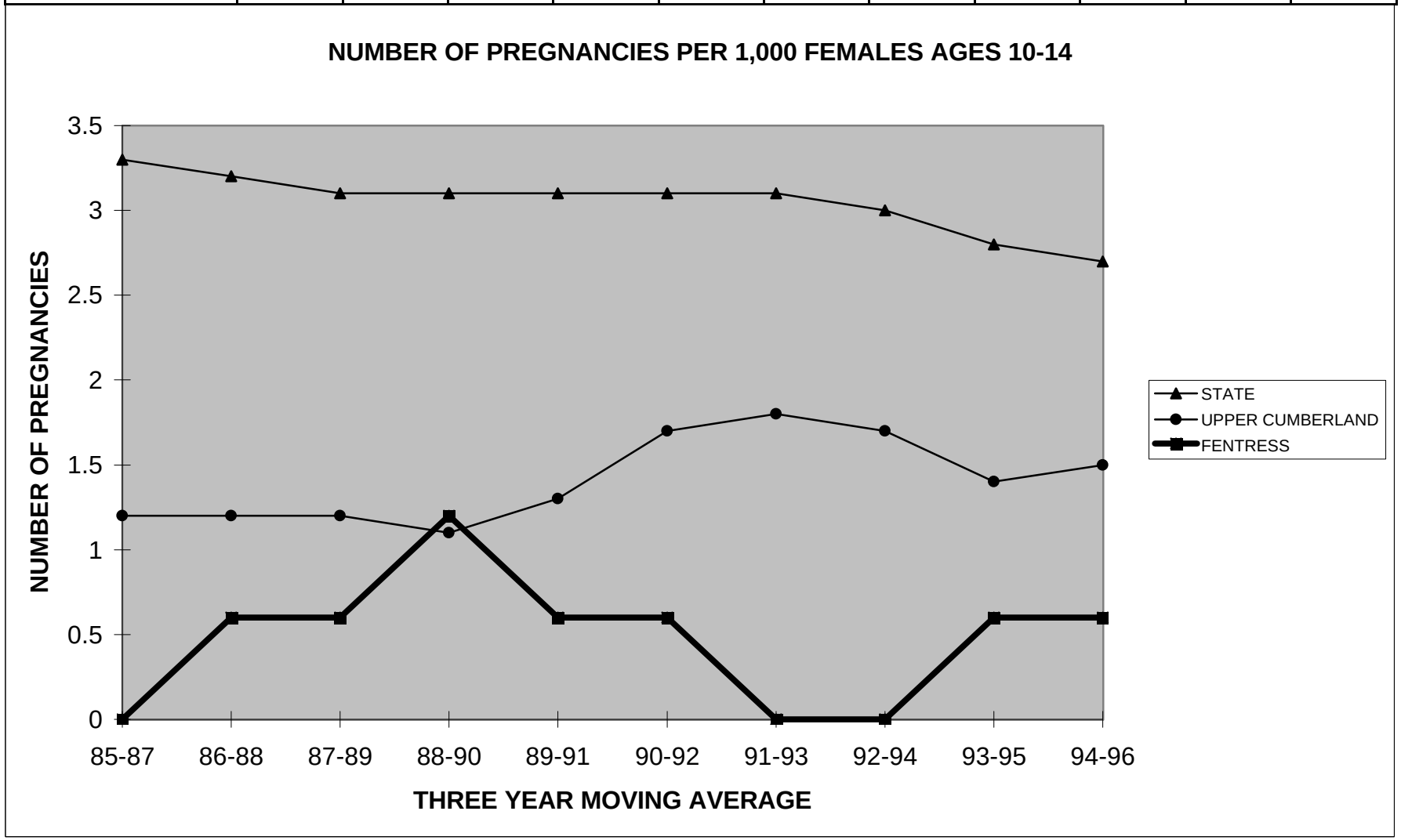
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	26.4	27.7	29.0	30.5	31.7	32.8	33.2	33.4	33.3	33.5	
UPPER CUMBERLAND	15.7	16.4	16.9	18.2	19.6	20.9	21.7	21.8	22.9	23.5	
FENTRESS	18.9	18.4	17.1	18.1	18.9	20.2	20.2	21.1	22.7	23.8	



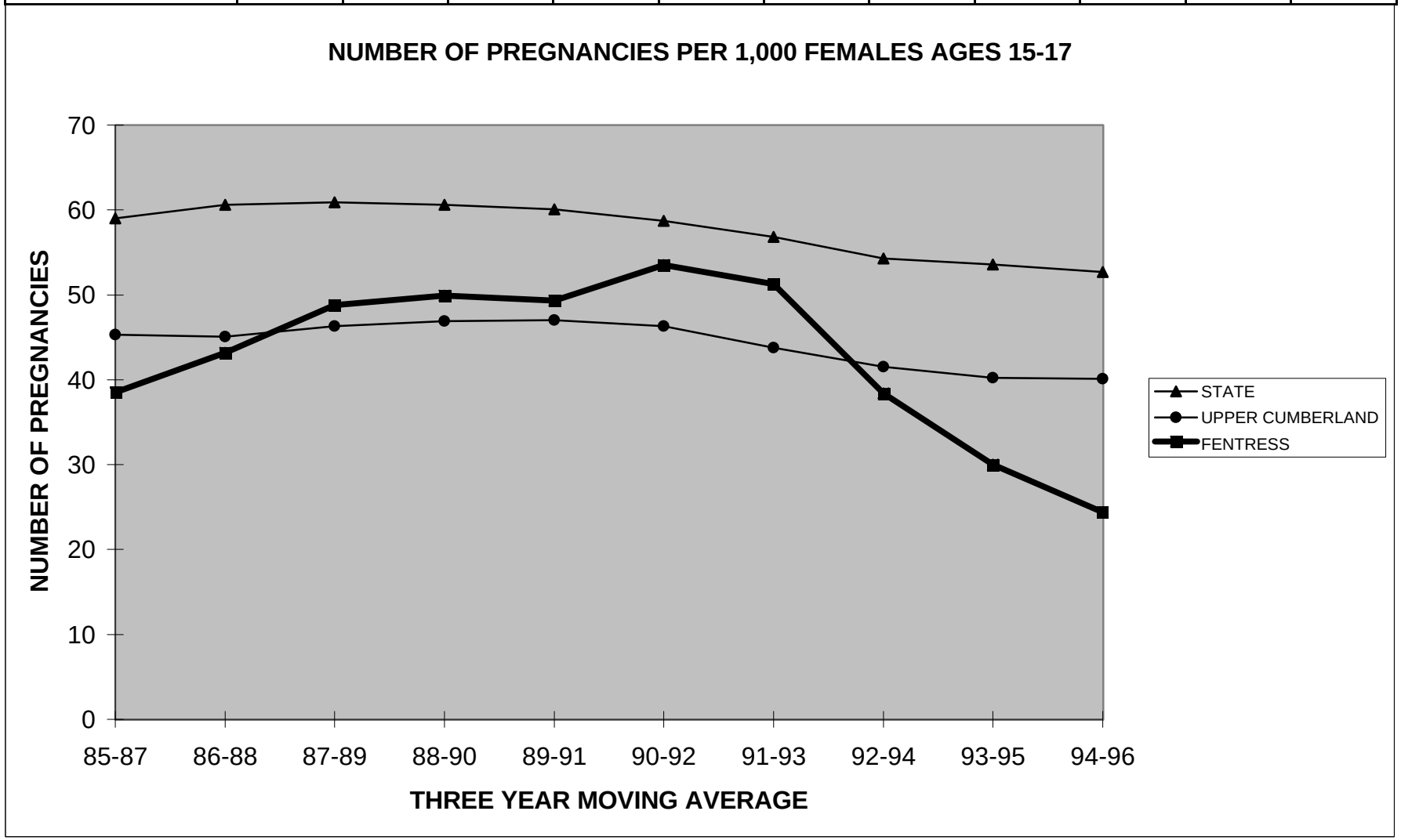
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	52.2	53.7	55.3	56.0	55.8	55.0	54.3	53.9	53.7	53.7	
UPPER CUMBERLAND	46.8	48.4	50.6	51.6	51.4	50.2	50.2	50.6	51.8	52.3	
FENTRESS	48.0	49.9	48.9	50.7	50.6	50.9	49.0	52.6	53.6	55.0	



	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	3.3	3.2	3.1	3.1	3.1	3.1	3.1	3	2.8	2.7	
UPPER CUMBERLAND	1.2	1.2	1.2	1.1	1.3	1.7	1.8	1.7	1.4	1.5	
FENTRESS	0	0.6	0.6	1.2	0.6	0.6	0	0	0.6	0.6	



	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	59	60.6	60.9	60.6	60.1	58.7	56.8	54.3	53.6	52.7	
UPPER CUMBERLAND	45.3	45.1	46.3	46.9	47	46.3	43.8	41.5	40.2	40.1	
FENTRESS	38.5	43.2	48.8	49.9	49.3	53.5	51.3	38.4	30	24.4	



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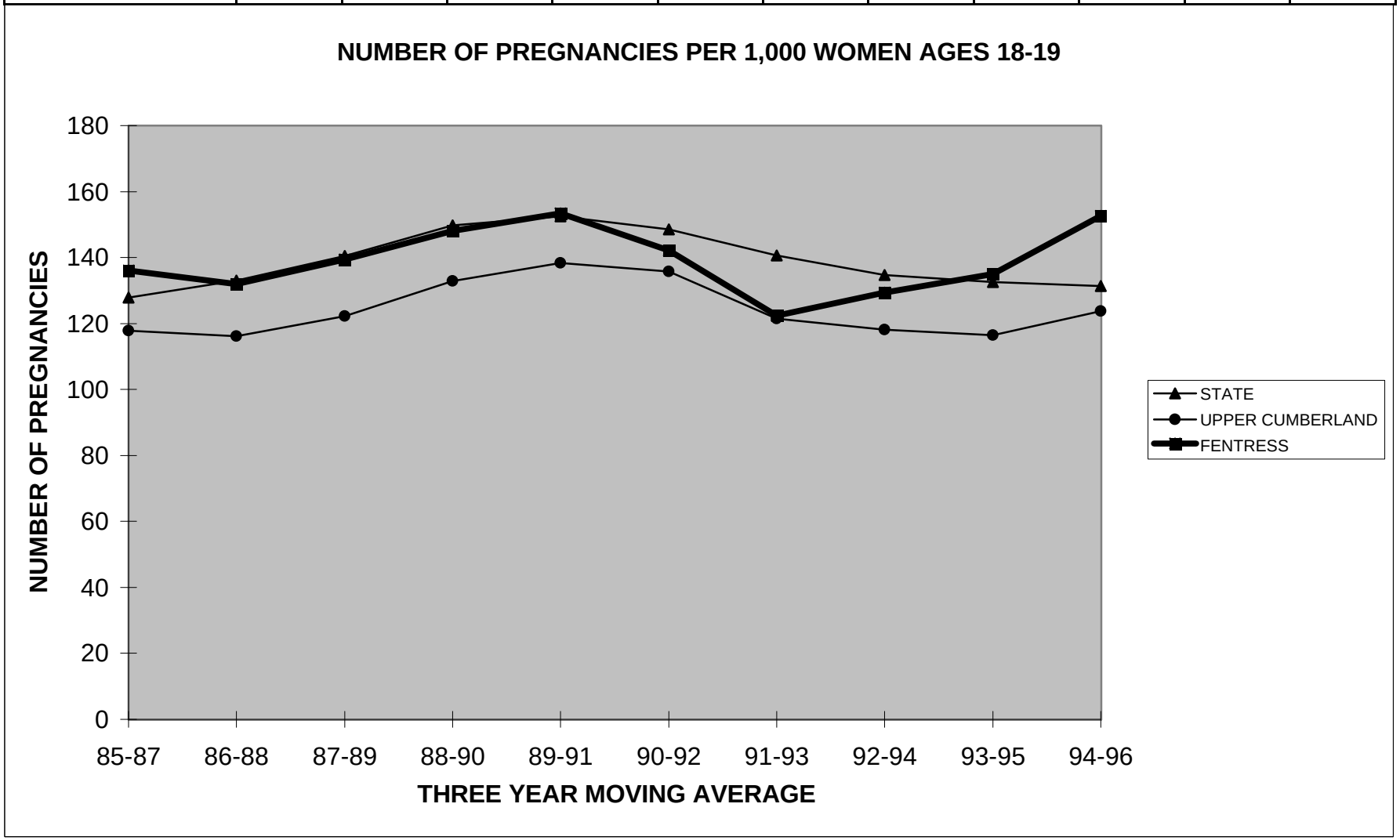
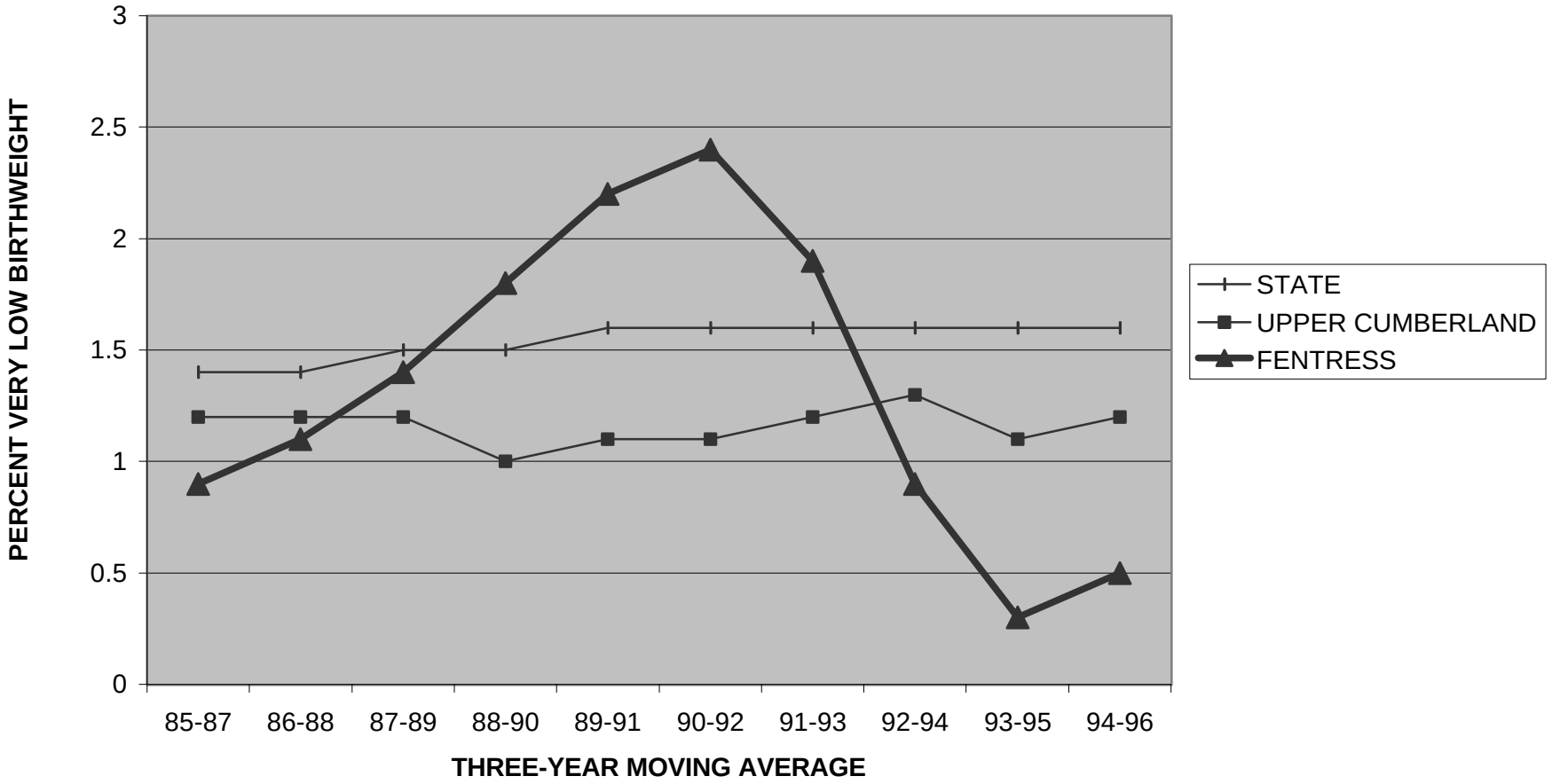
STATE	127.8	133	140.4	149.8	152.5	148.5	140.7	134.7	132.6	131.3	
UPPER CUMBERLAND	117.8	116.2	122.2	132.8	138.4	135.8	121.5	118.2	116.5	123.8	
FENTRESS	136	132	139.4	148.1	153.4	142.2	122.4	129.4	135	152.7	

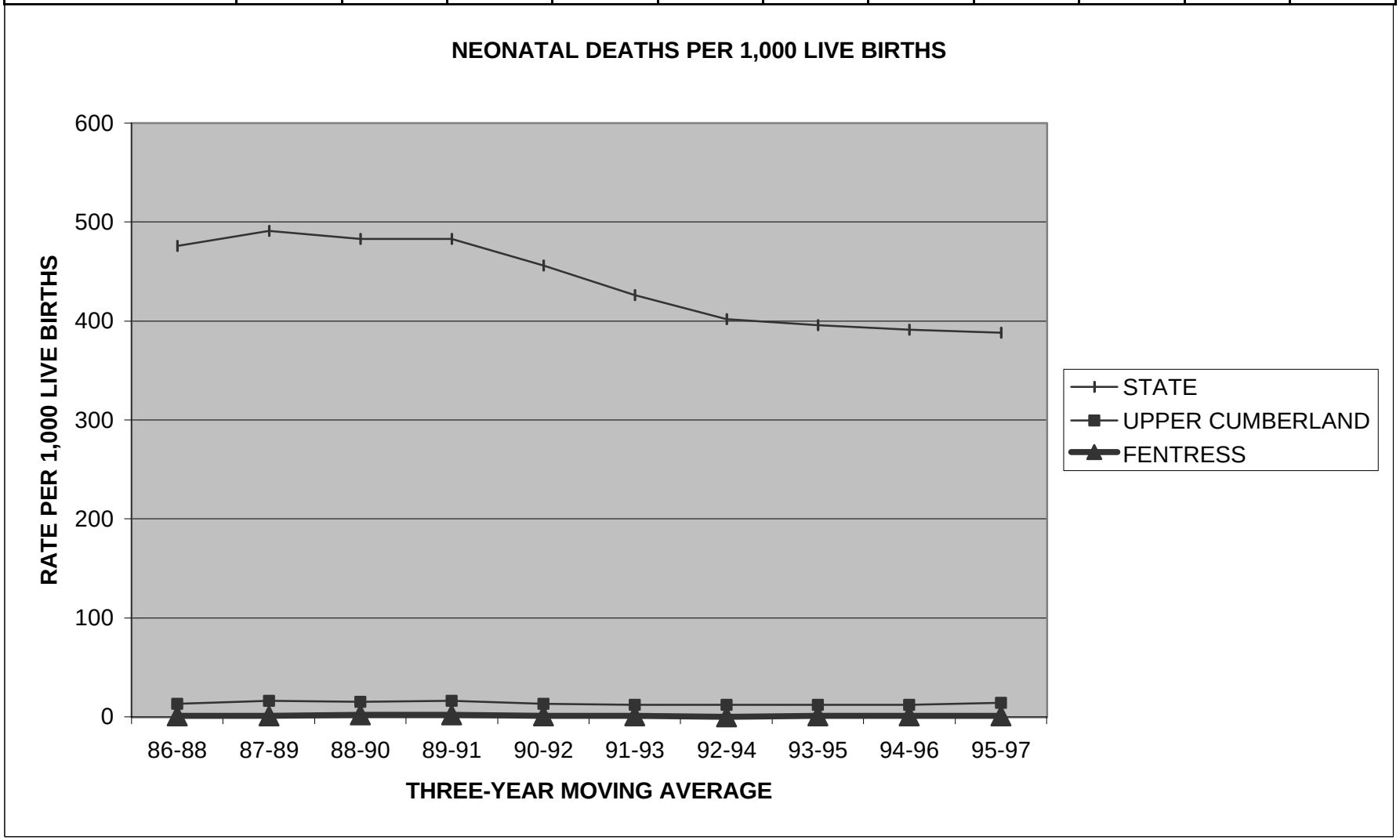


	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	1.4	1.4	1.5	1.5	1.6	1.6	1.6	1.6	1.6	1.6	
UPPER CUMBERLAND	1.2	1.2	1.2	1	1.1	1.1	1.2	1.3	1.1	1.2	
FENTRESS	0.9	1.1	1.4	1.8	2.2	2.4	1.9	0.9	0.3	0.5	

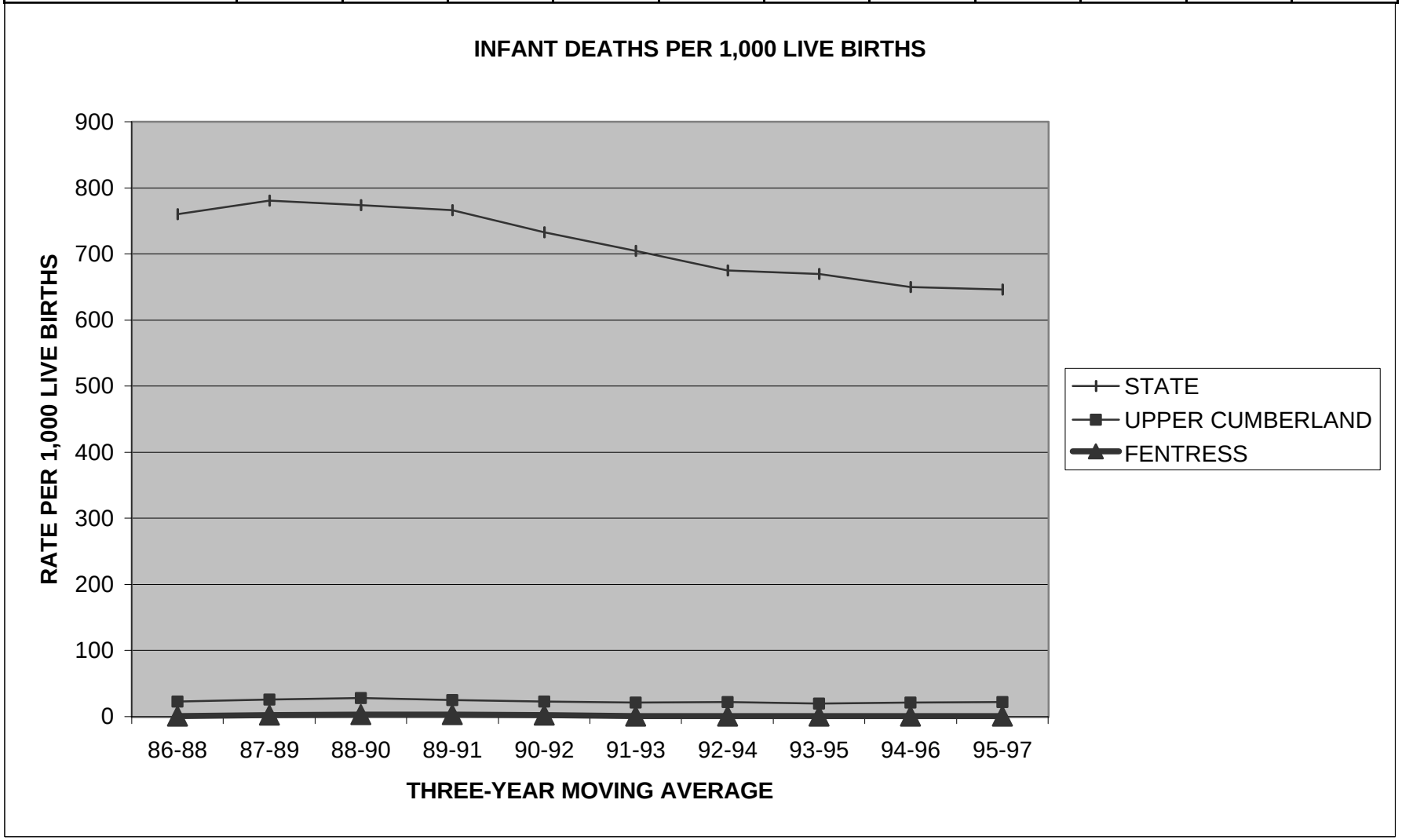
PERCENT OF LIVE BIRTHS CLASSIFIED AS VERY LOW BIRTHWEIGHT, AGES 10-44



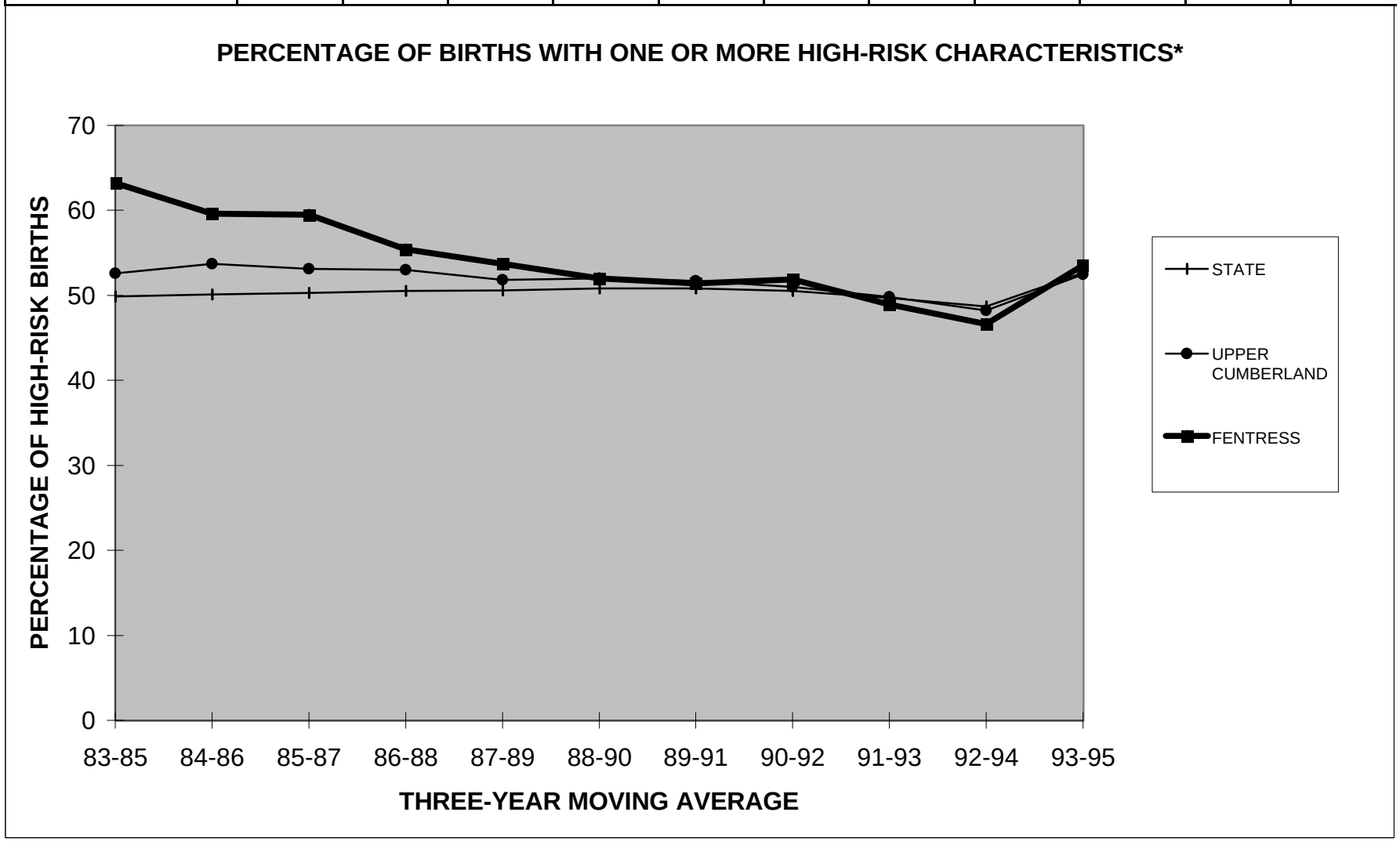
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	476	491	483	483	456	426	402	396	391	388	
UPPER CUMBERLAND	13	16	15	16	13	12	12	12	12	14	
FENTRESS	1	1	2	2	1	1	0	1	1	1	



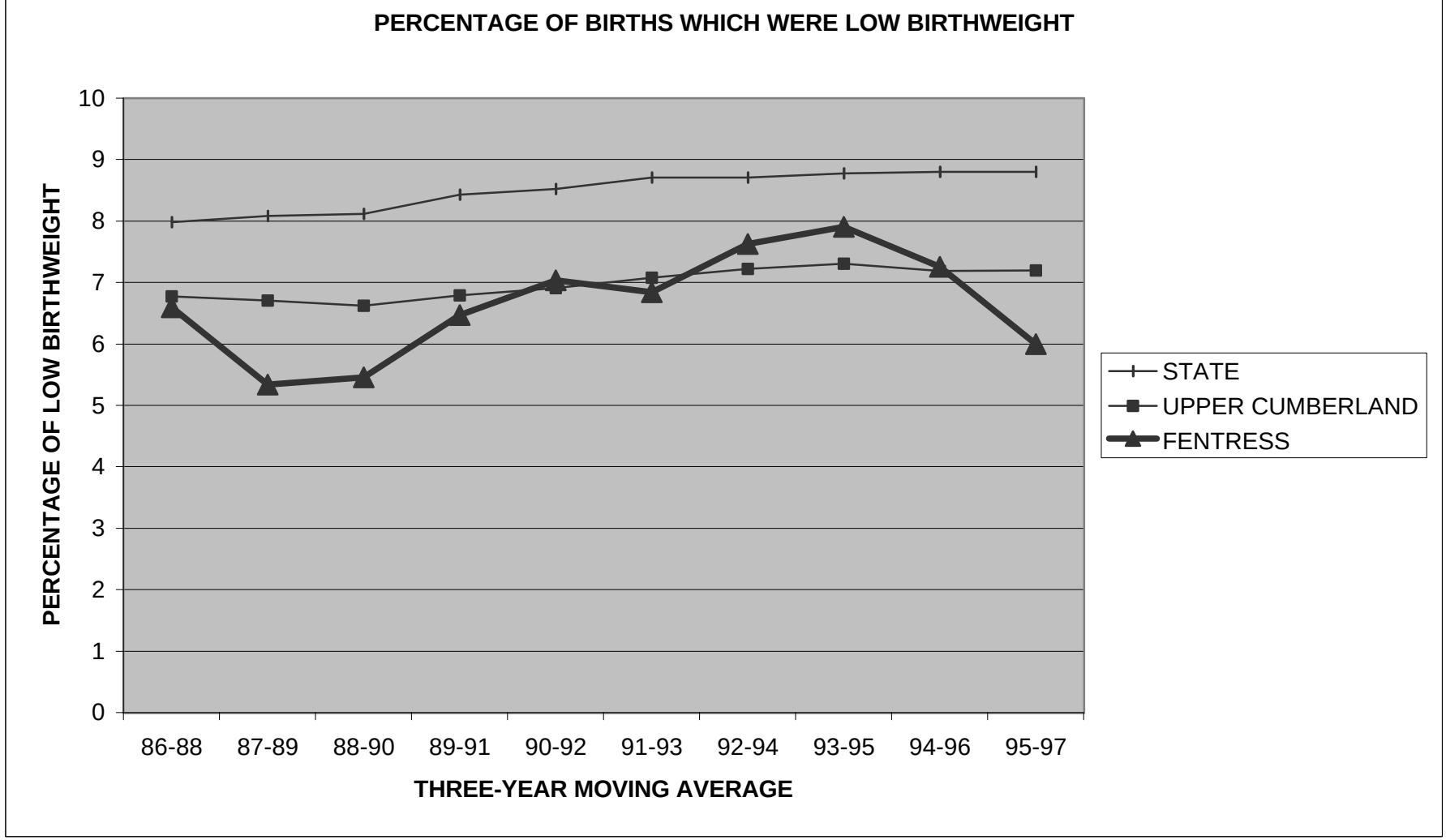
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	760	781	774	766	733	705	675	670	650	646	
UPPER CUMBERLAND	23	26	28	25	23	21	22	20	21	22	
FENTRESS	1	2	3	3	2	1	1	1	1	1	



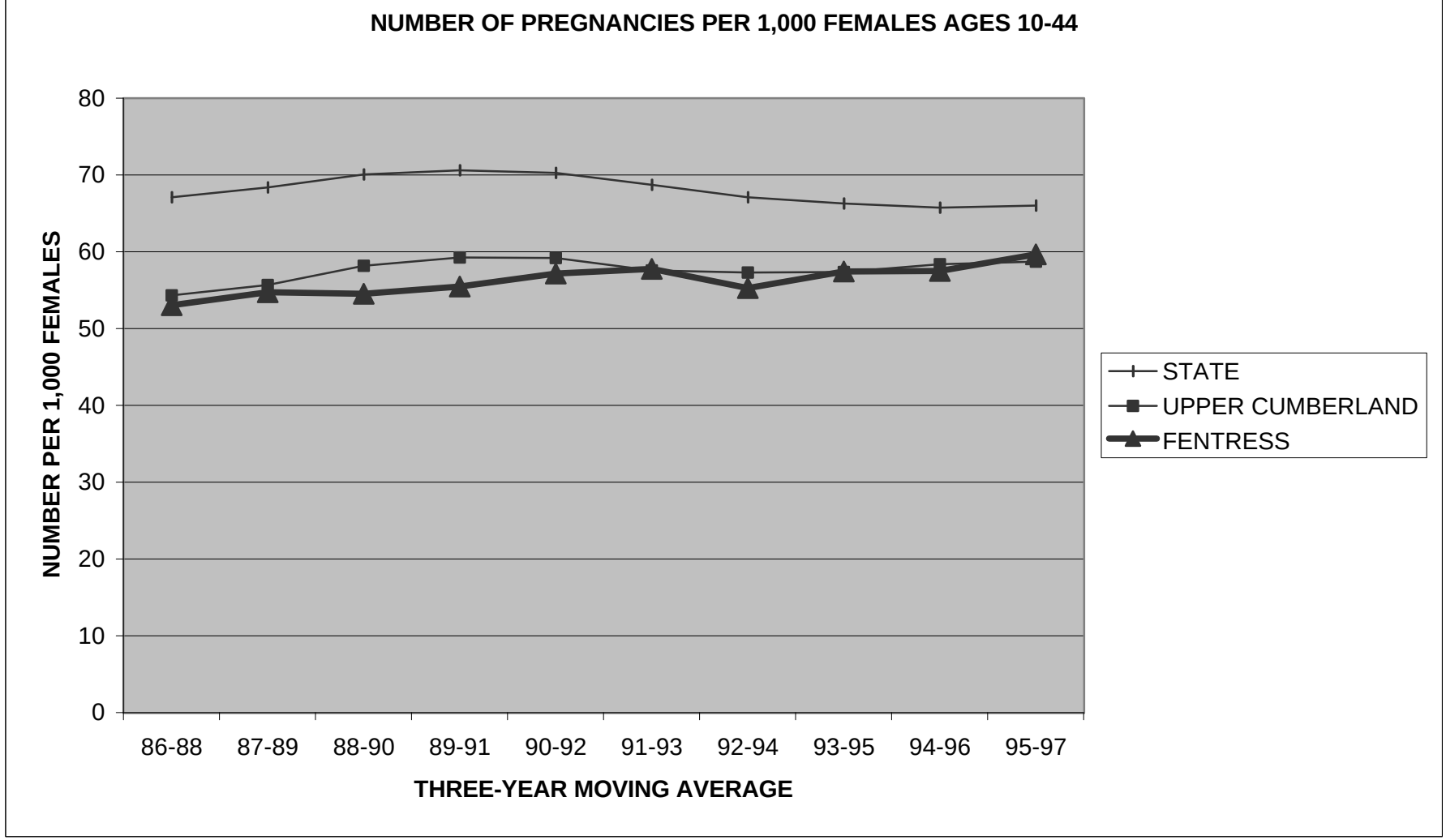
	83-85	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95
STATE	49.9	50.1	50.3	50.5	50.6	50.8	50.8	50.5	49.7	48.7	52.6
UPPER CUMBERLAND	52.6	53.7	53.1	53	51.8	52	51.7	51	49.8	48.2	52.5
FENTRESS	63.2	59.6	59.5	55.4	53.7	52	51.4	51.9	48.9	46.6	53.5



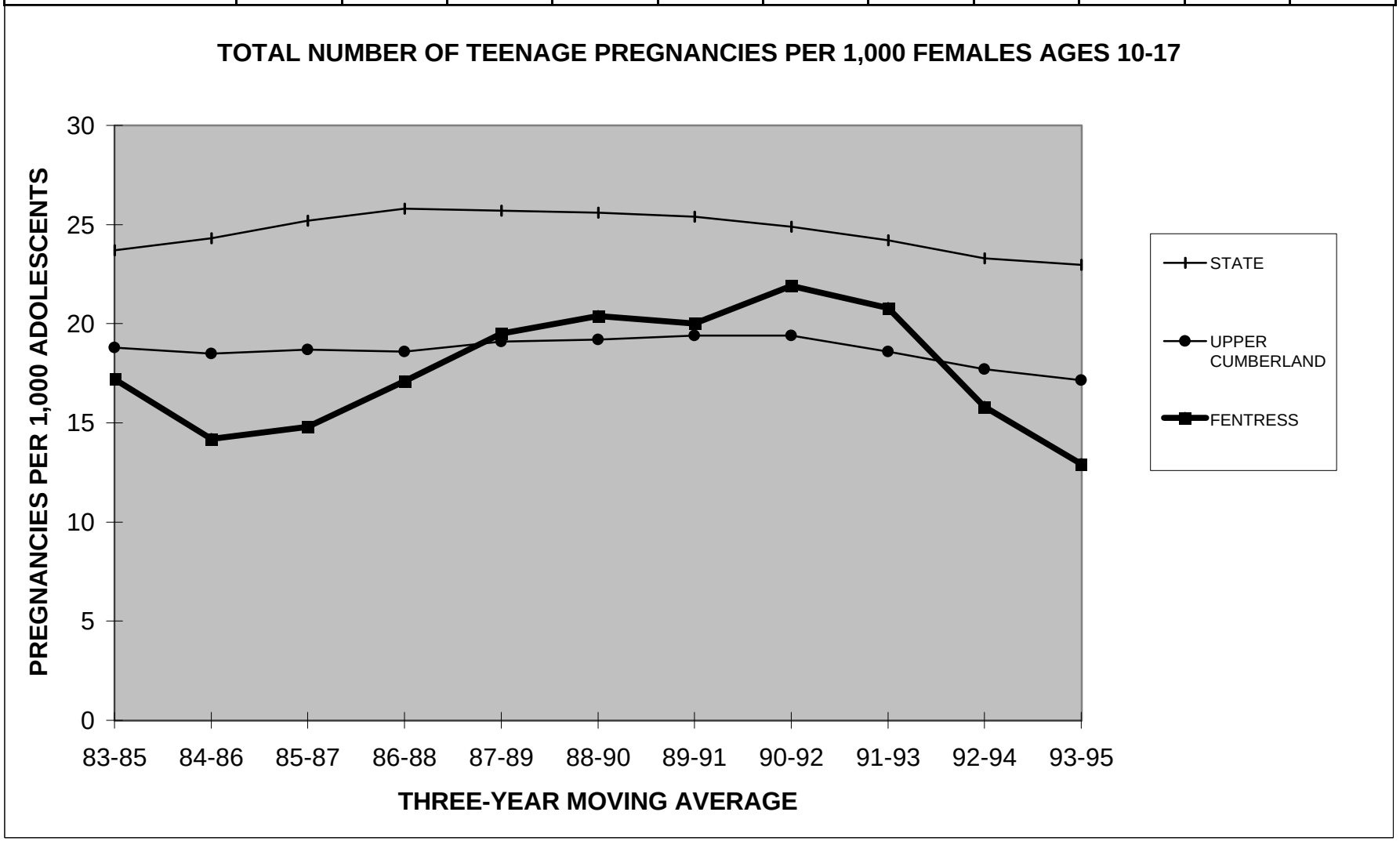
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	8.0	8.1	8.1	8.4	8.5	8.7	8.7	8.8	8.8	8.8	
UPPER CUMBERLAND	6.8	6.7	6.6	6.8	6.9	7.1	7.2	7.3	7.2	7.2	
FENTRESS	6.6	5.3	5.5	6.5	7.0	6.8	7.6	7.9	7.3	6.0	



	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	67.1	68.4	70.1	70.6	70.3	68.7	67.1	66.3	65.8	66.0	
UPPER CUMBERLAND	54.3	55.6	58.2	59.2	59.2	57.6	57.3	57.4	58.4	58.7	
FENTRESS	53.0	54.7	54.5	55.5	57.2	57.7	55.2	57.4	57.5	59.6	



	83-85	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95
STATE	23.7	24.3	25.2	25.8	25.7	25.6	25.4	24.9	24.2	23.3	23.0
UPPER CUMBERLAND	18.8	18.5	18.7	18.6	19.1	19.2	19.4	19.4	18.6	17.7	17.2
FENTRESS	17.2	14.2	14.8	17.1	19.5	20.4	20	21.9	20.8	15.8	12.9

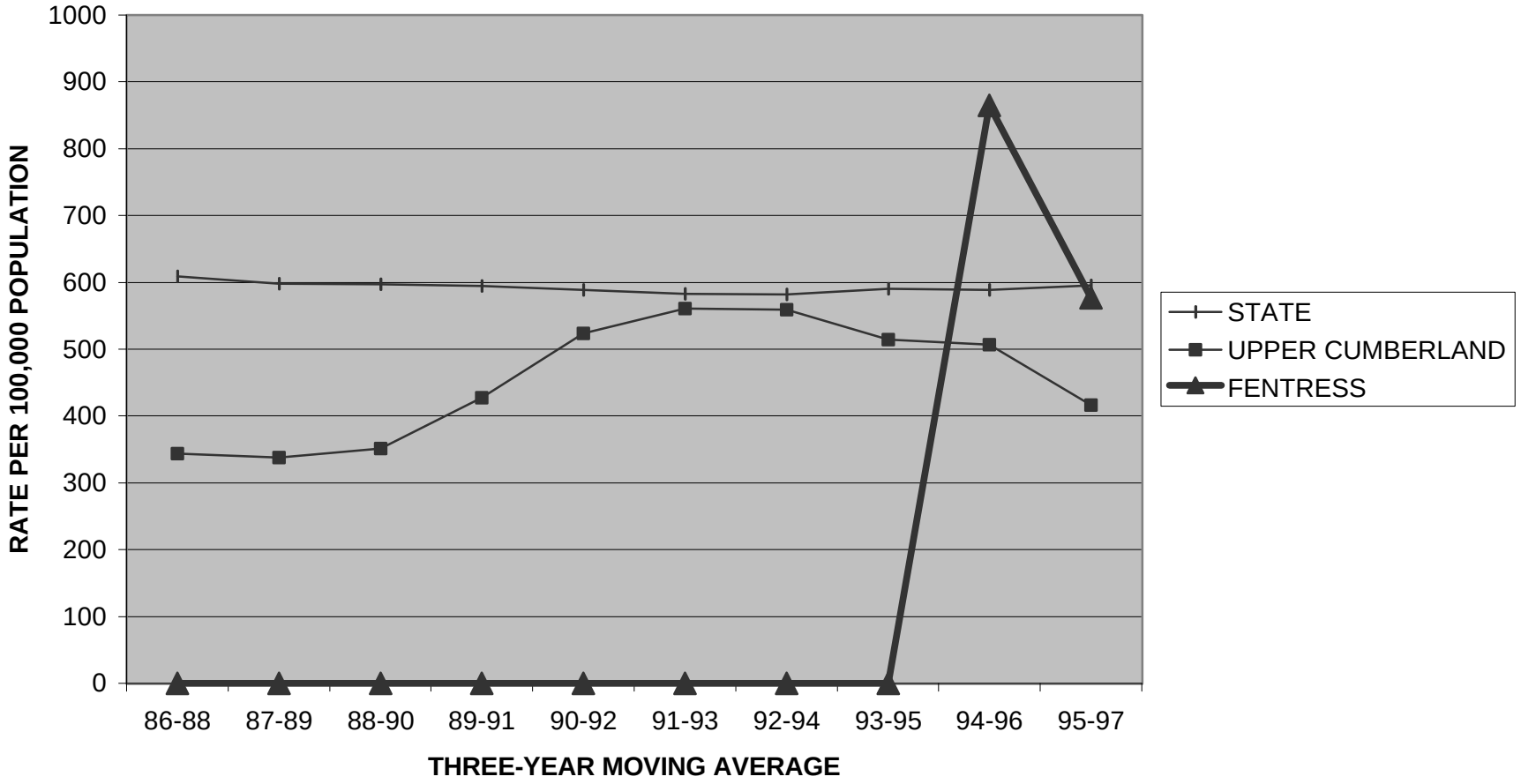


Appendix 4

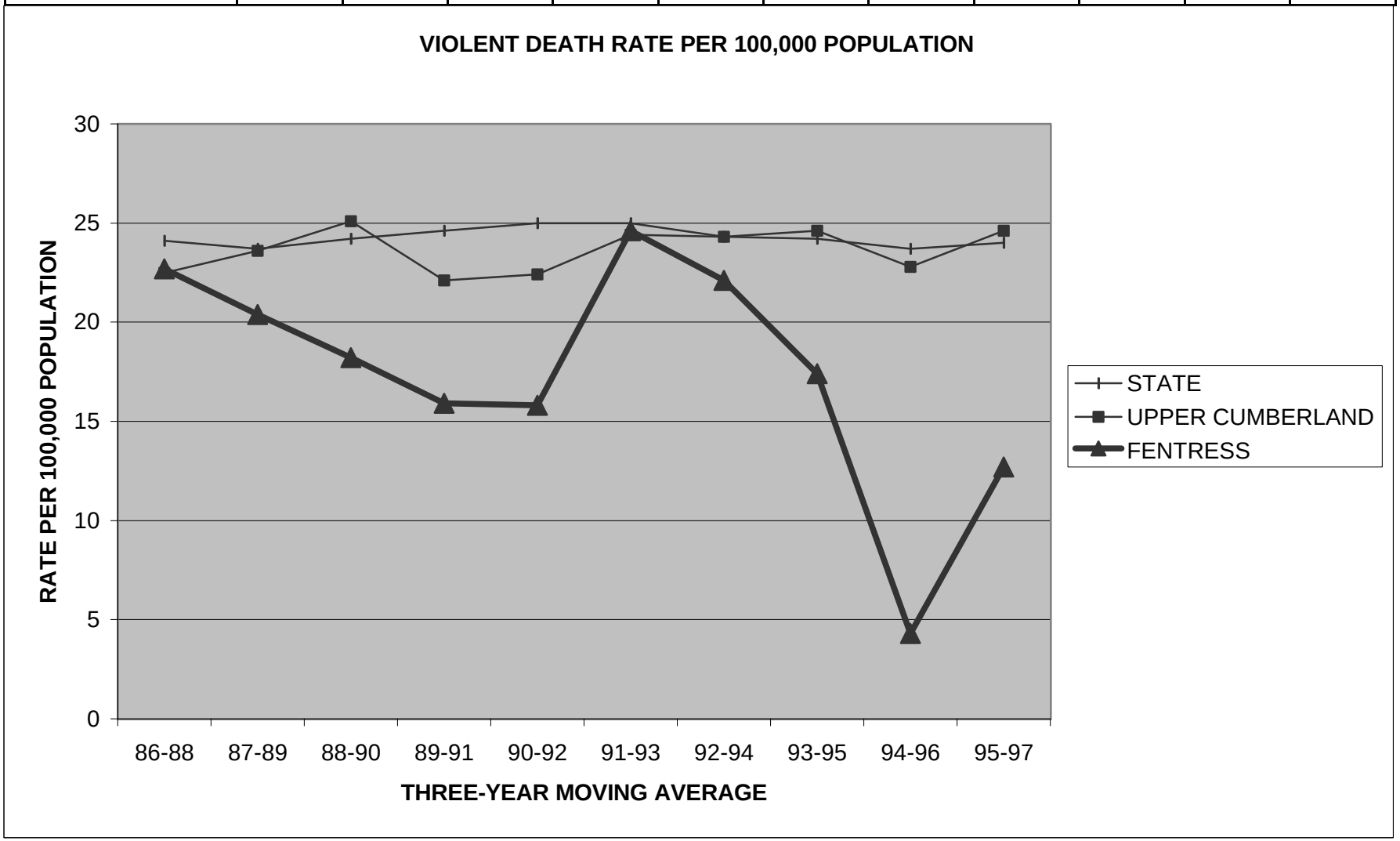
Mortality Data

	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	608.9	598.3	596.8	594.4	588.8	582.7	582.2	590.6	588.7	595.7	
UPPER CUMBERLAND	344.0	337.6	351.2	427.2	523.4	560.8	559.5	514.1	506.7	416.7	
FENTRESS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	865.2	576.8	

OTHER RACES FEMALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION

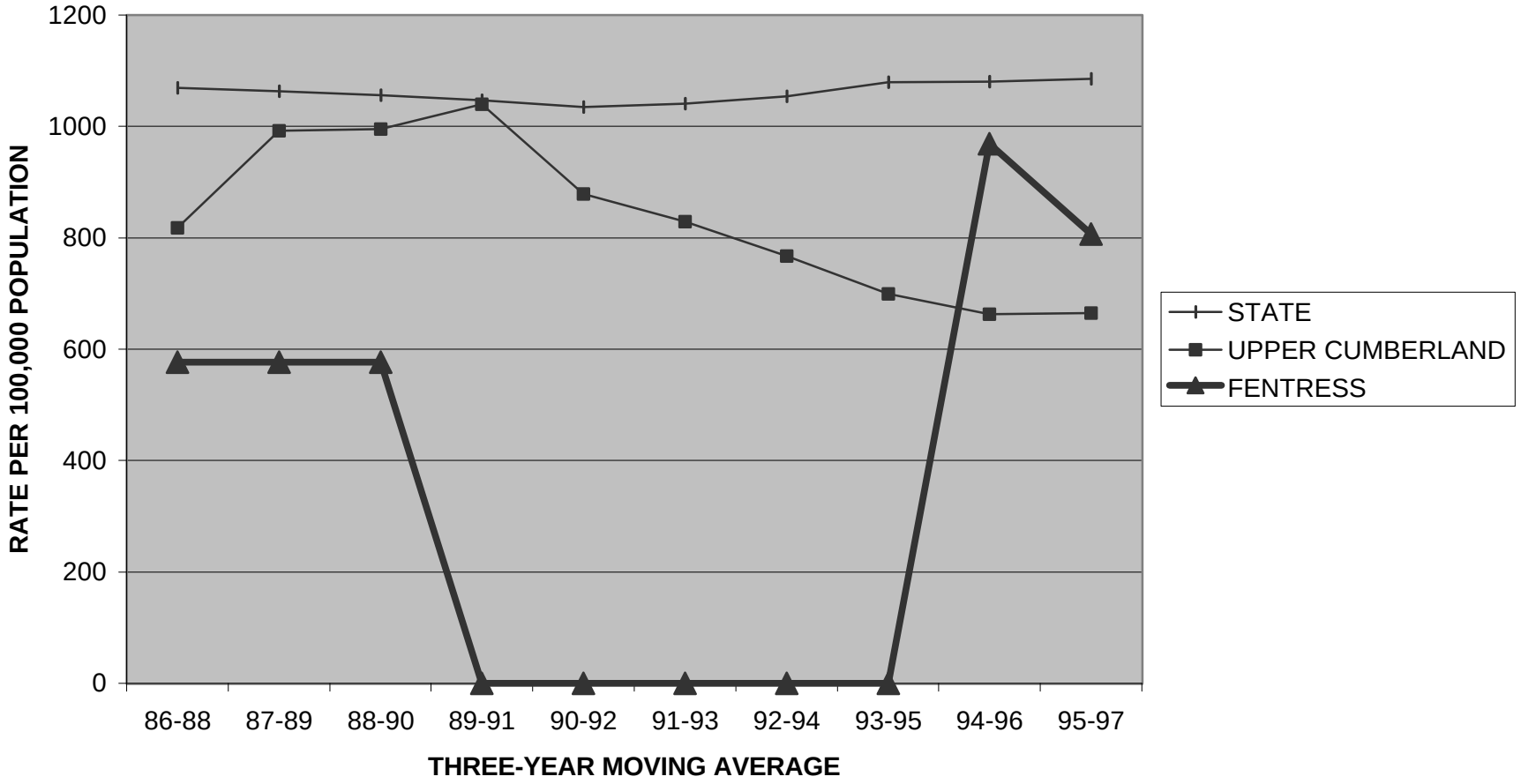


	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	24.1	23.7	24.2	24.6	25.0	25.0	24.3	24.2	23.7	24.0	
UPPER CUMBERLAND	22.5	23.6	25.1	22.1	22.4	24.4	24.3	24.6	22.8	24.6	
FENTRESS	22.7	20.4	18.2	15.9	15.8	24.6	22.1	17.4	4.3	12.7	



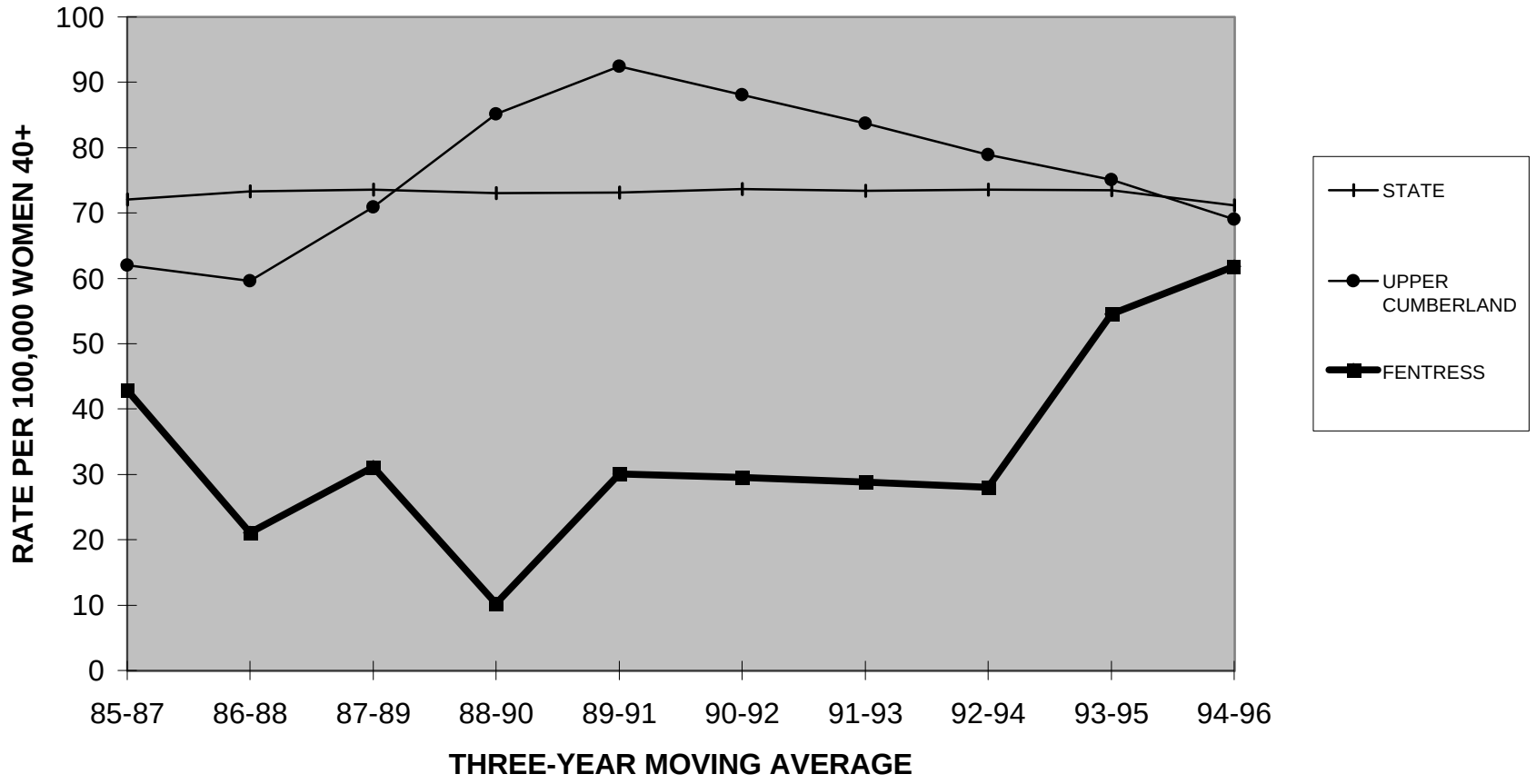
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	1,068.8	1,063.0	1,056.2	1,046.5	1,034.4	1,040.8	1,054.3	1,079.7	1,080.0	1,085.8	
UPPER CUMBERLAND	817.8	992.0	995.6	1,039.8	878.9	829.4	766.8	699.8	663.0	665.1	
FENTRESS	576.8	576.8	576.8	0.0	0.0	0.0	0.0	0.0	968.5	807.1	

OTHER RACES MALE AGE-ADJUSTED MORTALITY RATE PER 100,000 POPULATION

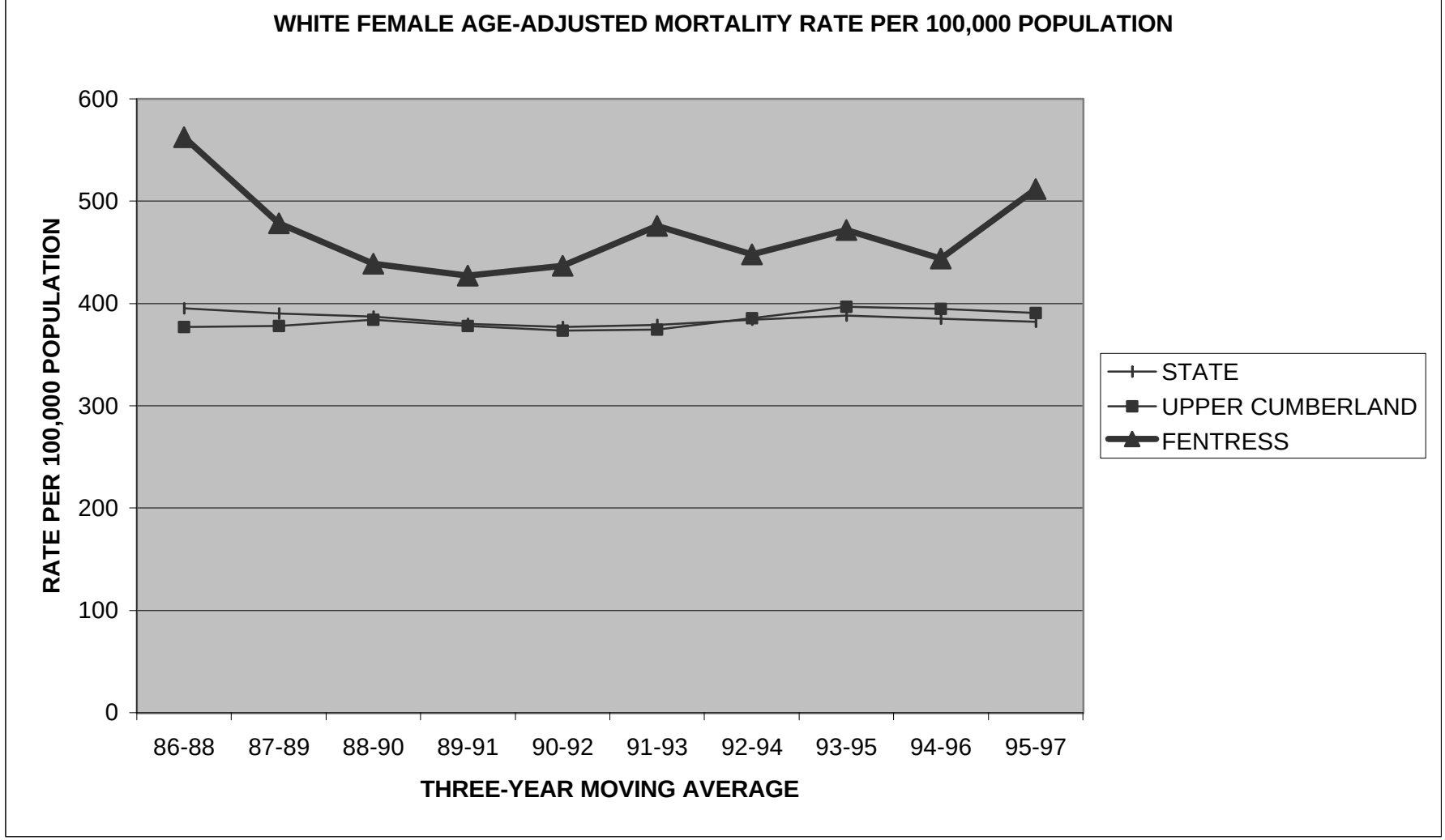


	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	
STATE	72.1	73.3	73.6	73	73.1	73.7	73.4	73.6	73.5	71.2	
UPPER CUMBERLAND	62	59.6	70.9	85.1	92.4	88.1	83.7	78.9	75.1	69	
FENTRESS	42.9	21.1	31.1	10.2	30.1	29.5	28.8	28	54.5	61.8	

FEMALE BREAST CANCER MORTALITY RATE PER 100,000 WOMEN AGES 40 YEARS AND OLDER

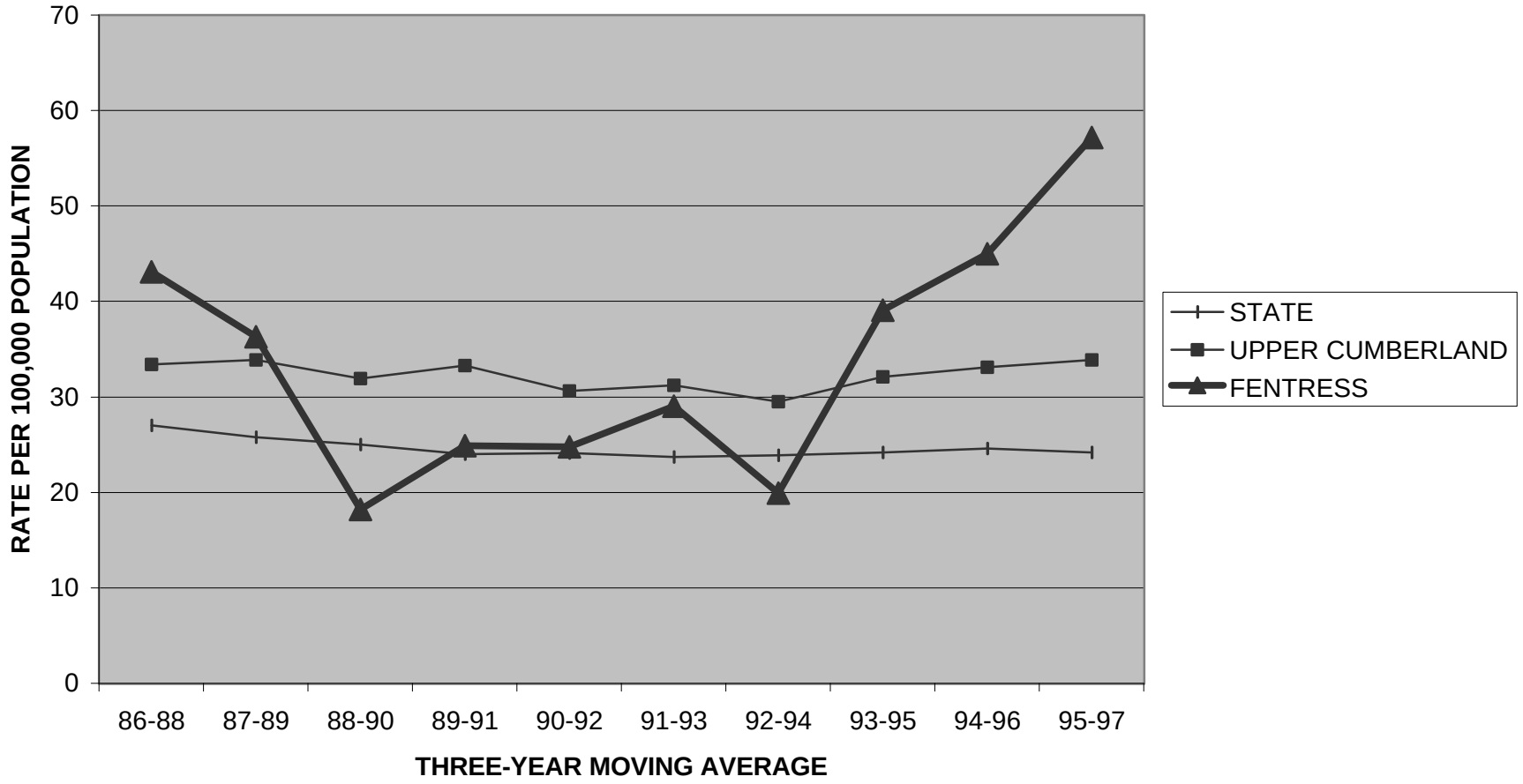


	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	395.1	390.0	387.1	380.2	377.2	379.0	384.3	388.0	385.3	381.9	
UPPER CUMBERLAND	377.1	378.1	384.2	378.2	373.6	374.7	385.7	396.6	394.7	390.5	
FENTRESS	562.4	478.3	438.6	427.3	437.0	475.8	448.1	472.0	443.7	511.8	

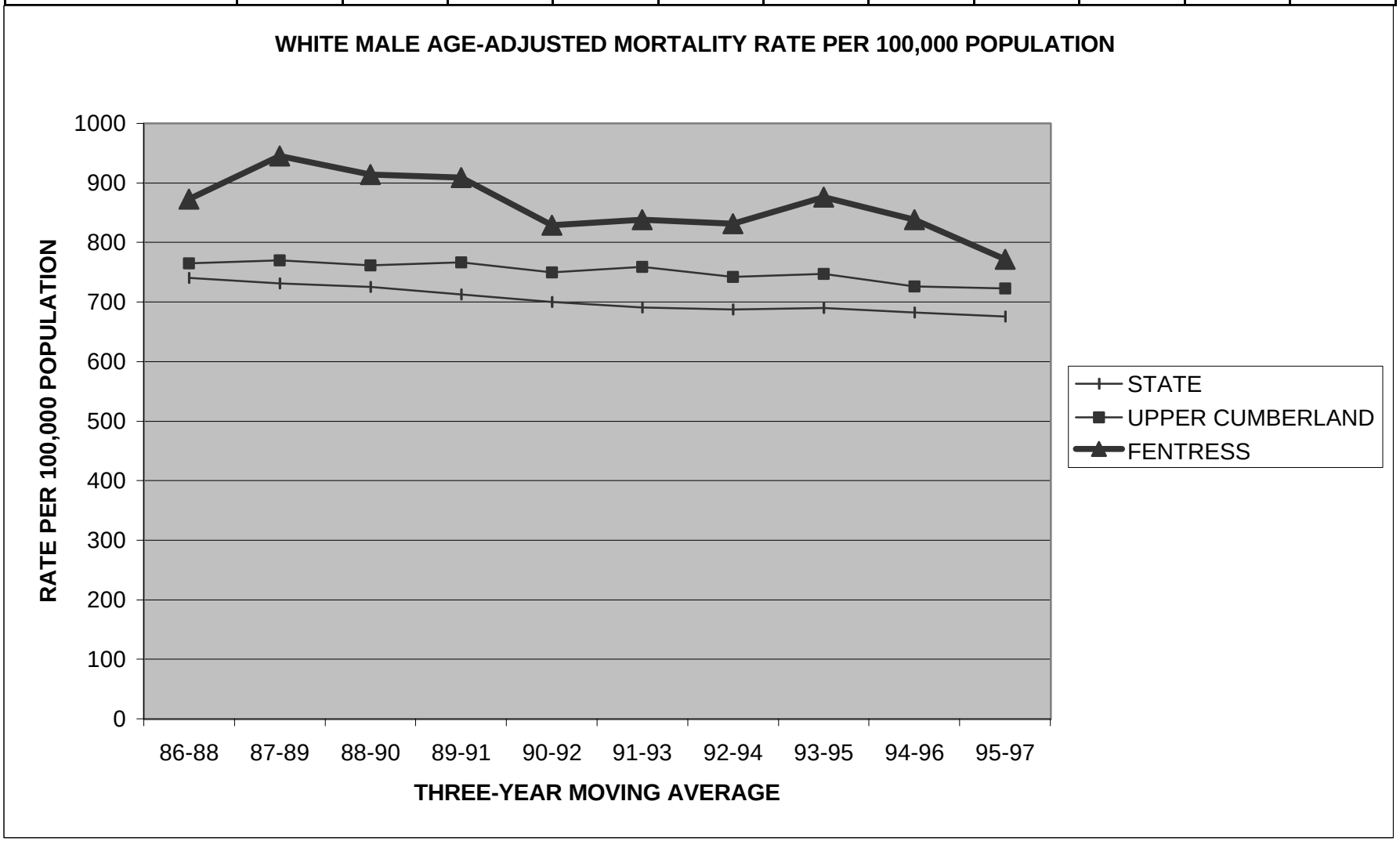


	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	27.0	25.8	25.0	24.0	24.1	23.7	23.9	24.2	24.6	24.2	
UPPER CUMBERLAND	33.4	33.9	31.9	33.3	30.6	31.2	29.5	32.1	33.1	33.9	
FENTRESS	43.1	36.3	18.2	24.9	24.8	29.0	19.9	39.1	45.0	57.2	

MOTOR VEHICLE ACCIDENTAL MORTALITY RATE PER 100,000 POPULATION



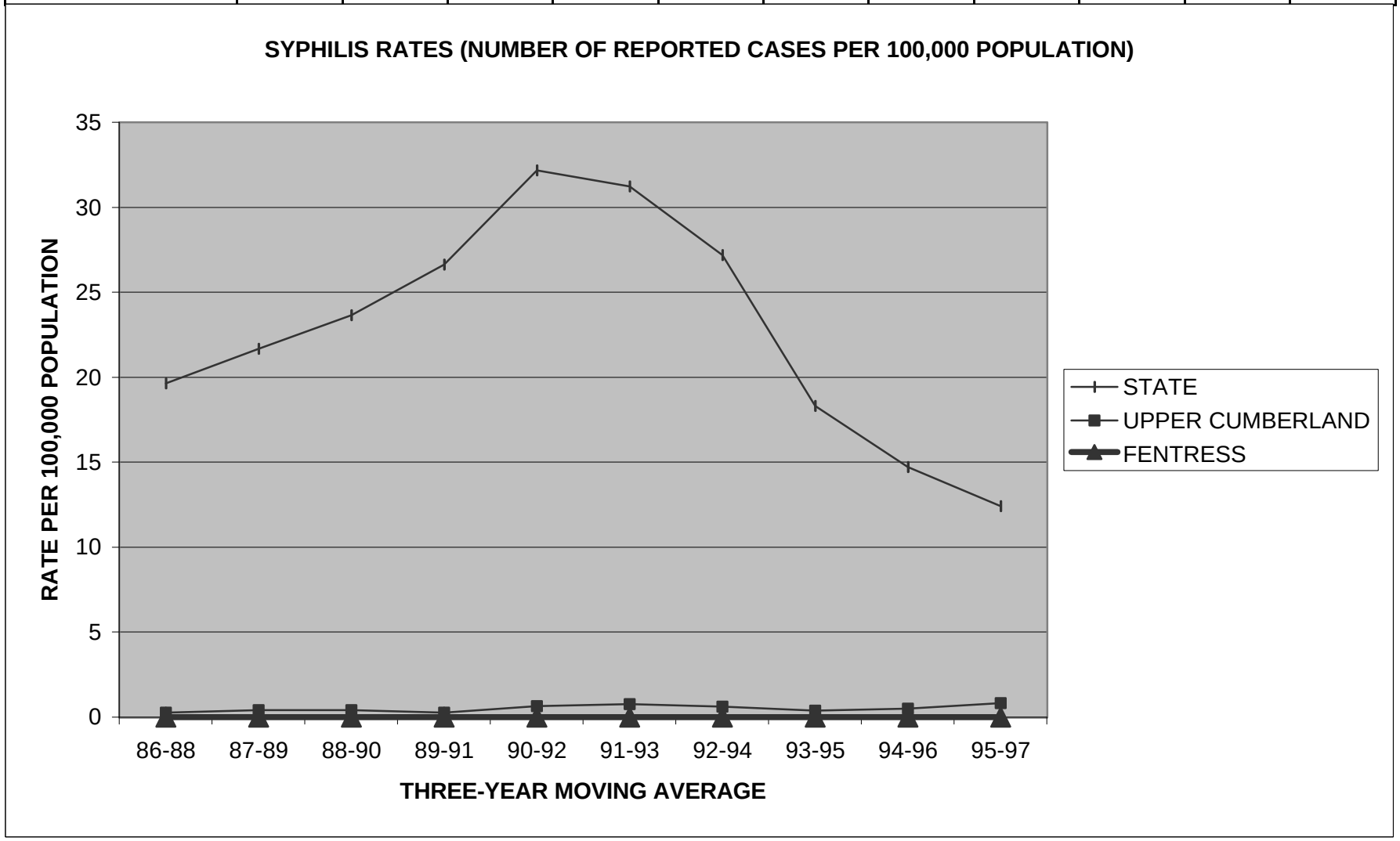
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	740.2	731.5	725.3	712.3	699.9	691.0	687.8	690.1	682.1	675.8	
UPPER CUMBERLAND	764.7	769.7	761.9	766.6	749.6	759.0	742.0	747.1	726.0	723.2	
FENTRESS	872.6	945.4	914.2	909.3	829.4	838.1	831.2	875.8	838.0	772.1	



Appendix 5

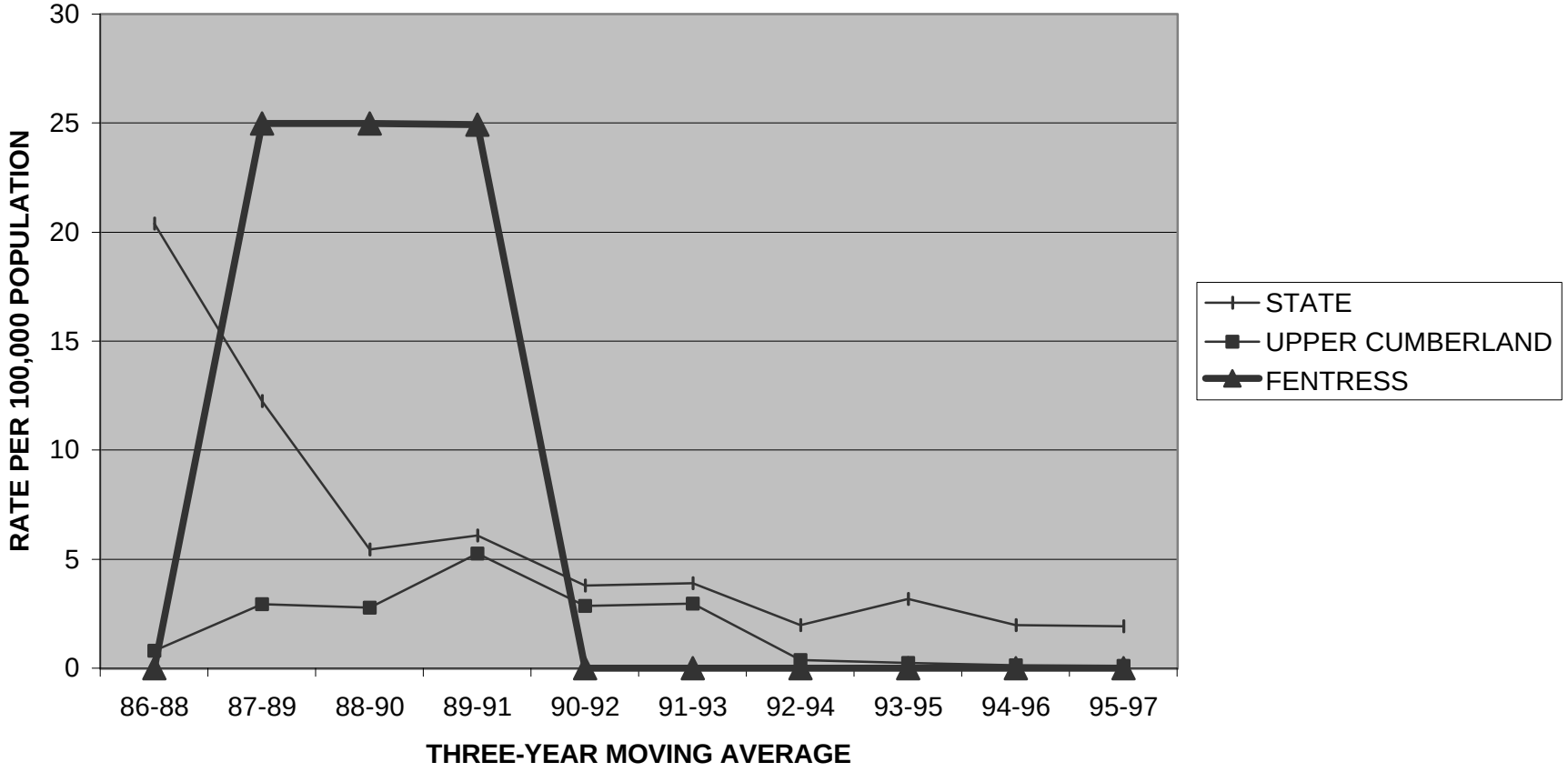
Morbidity Data

	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	19.6	21.7	23.7	26.6	32.2	31.2	27.2	18.3	14.7	12.4	
UPPER CUMBERLAND	0.3	0.4	0.4	0.3	0.7	0.8	0.6	0.4	0.5	0.8	
FENTRESS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	



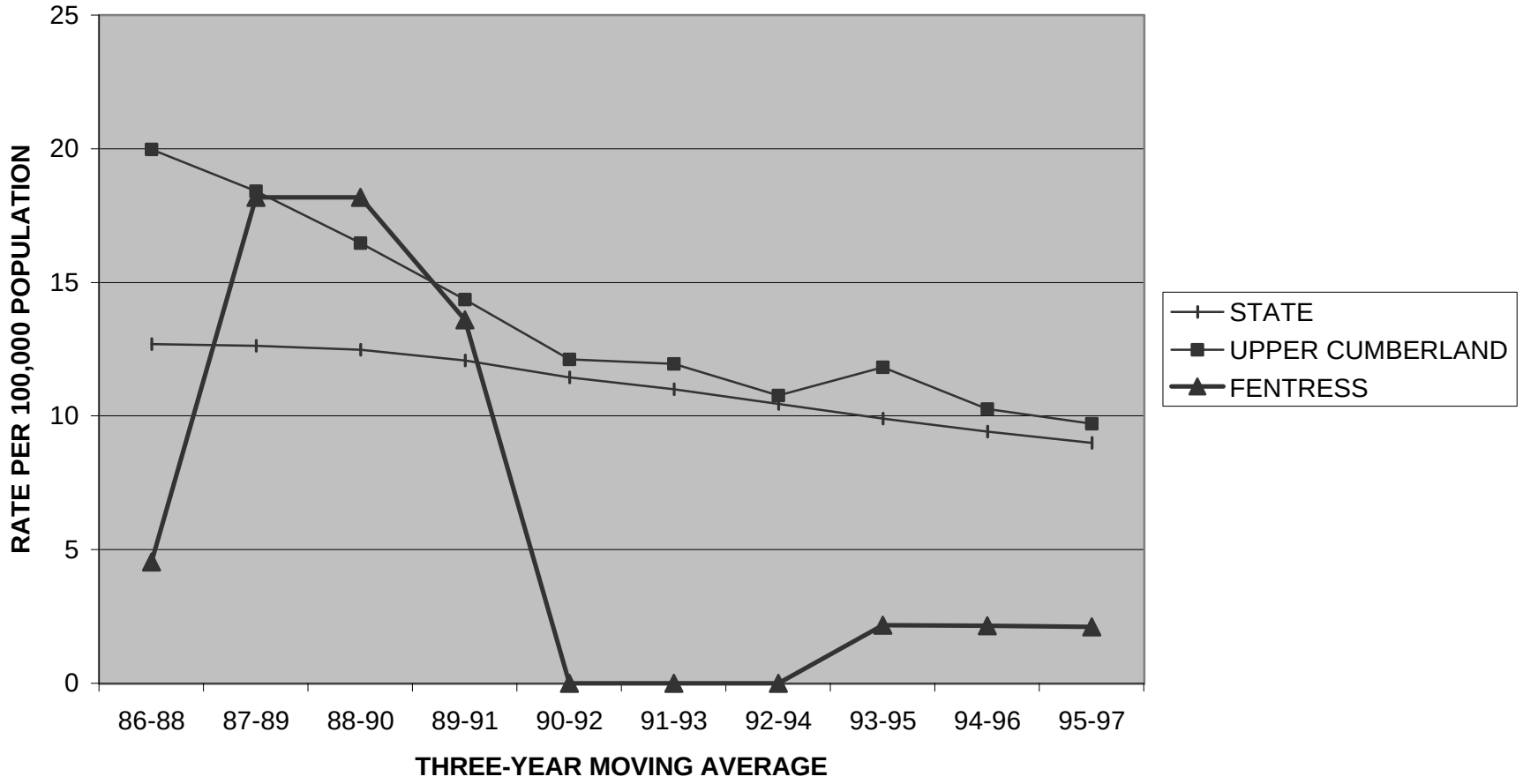
	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	20.4	12.3	5.5	6.1	3.8	3.9	2.0	3.2	2.0	1.9	
UPPER CUMBERLAND	0.8	2.9	2.8	5.3	2.9	3.0	0.4	0.2	0.1	0.1	
FENTRESS	0.0	25.0	25.0	24.9	0.0	0.0	0.0	0.0	0.0	0.0	

VACCINE-PREVENTABLE DISEASE RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)

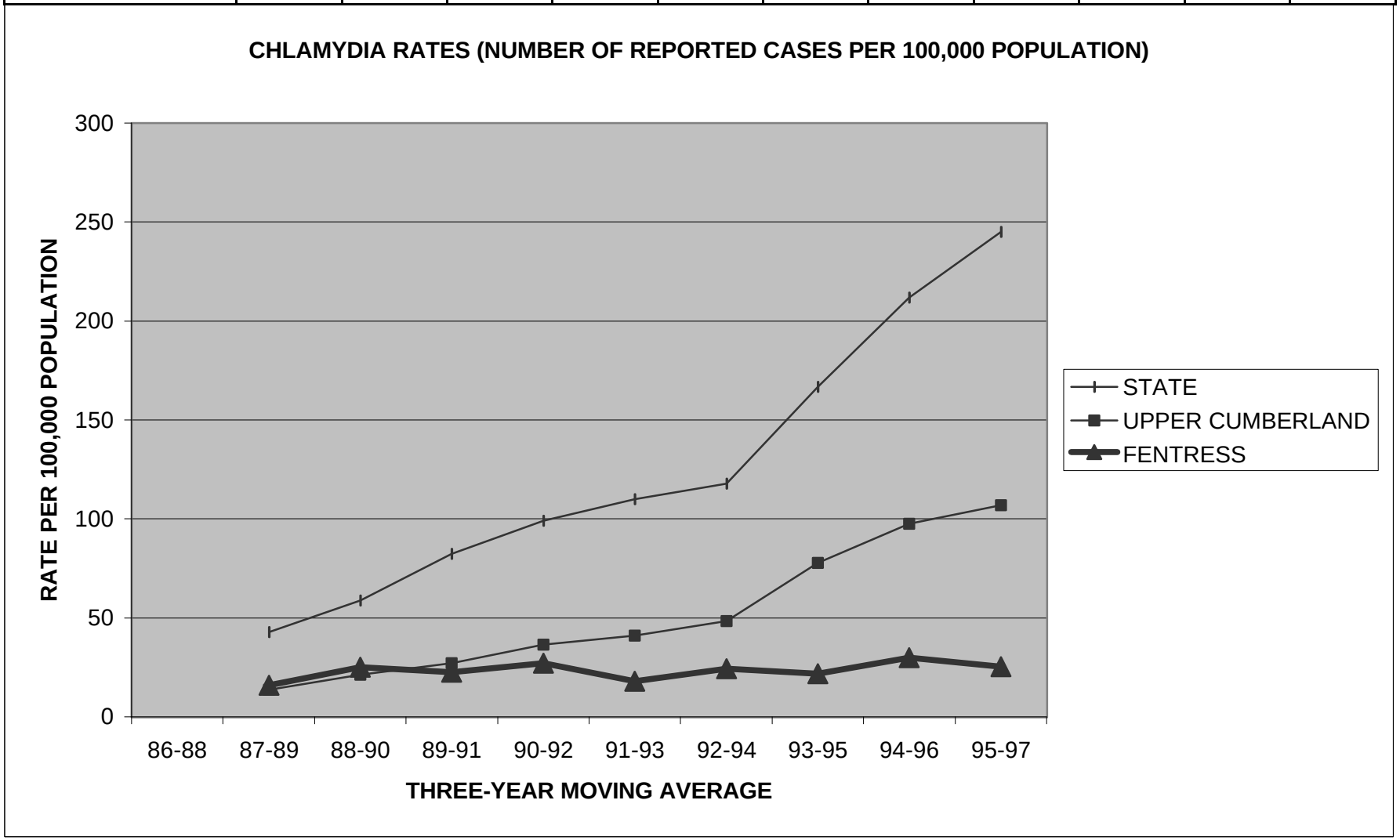


	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	12.7	12.6	12.5	12.1	11.4	11.0	10.5	9.9	9.4	9.0	
UPPER CUMBERLAND	20.0	18.4	16.5	14.4	12.1	12.0	10.8	11.8	10.3	9.7	
FENTRESS	4.5	18.2	18.2	13.6	0.0	0.0	0.0	2.2	2.1	2.1	

TUBERCULOSIS DISEASE RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)

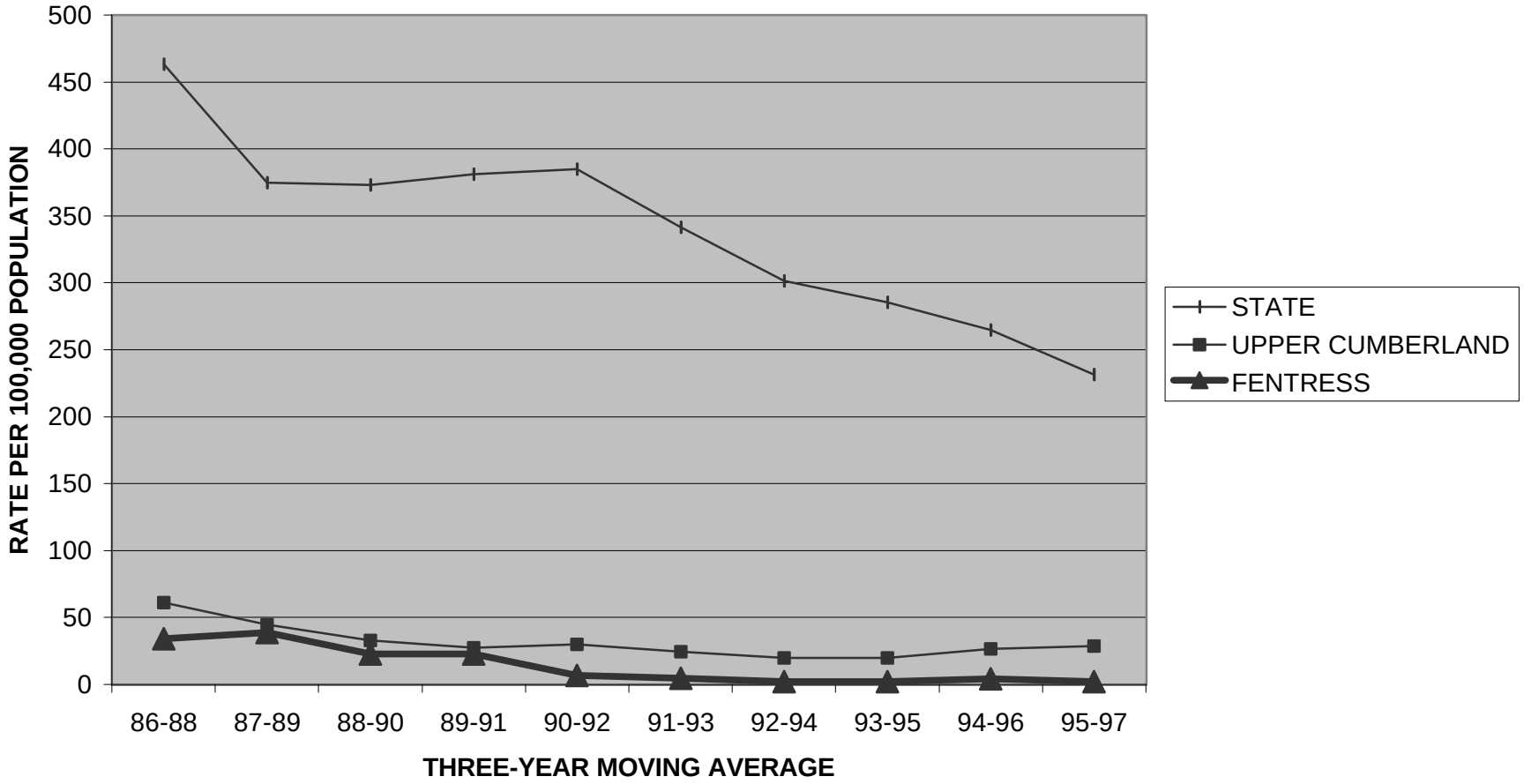


	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE		42.8	58.8	82.3	99.1	109.9	117.7	166.7	211.8	245.0	
UPPER CUMBERLAND		13.6	21.4	27.0	36.4	41.1	48.5	77.9	97.7	106.8	
FENTRESS		15.9	25.0	22.7	27.1	17.9	24.3	21.7	30.0	25.4	



	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	
STATE	463.3	374.6	373.3	380.9	385.0	341.5	301.5	285.3	264.7	231.4	
UPPER CUMBERLAND	61.1	44.8	33.1	27.5	30.0	24.6	19.6	19.7	26.5	28.8	
FENTRESS	34.1	38.6	22.7	22.7	6.8	4.5	2.2	2.2	4.3	2.1	

GONORRHEA RATES (NUMBER OF REPORTED CASES PER 100,000 POPULATION)



Appendix 6

Verbiage and Internet Address of HIT

Health Information Tennessee Web page created as a partnership between the TN Department of Health and the UTK Community Health Research Group can be located at: Server.to/hit